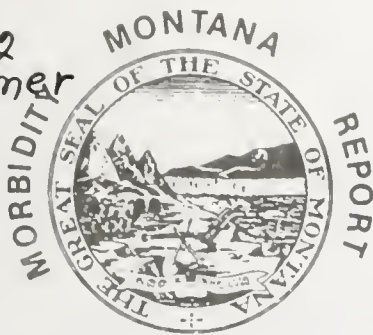


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VOL. 15:1

Montana State Department of Health and Environmental Sciences

* HIV/AIDS INFORMATION *

* INDEX *

AIDS Funding

The Montana Department of Health and Environmental Sciences held an informational public hearing to solicit input on the Title II Comprehensive Plan for Montana, which describes the proposed use and distribution of assistance received under Title II of the Ryan White Comprehensive AIDS Resources Emergency Act of 1990. The grant is to improve the quality, availability and organization of health care and support services for individuals and families with HIV infection, subsequent to the diagnosis of HIV infection. The hearing was held on February 20, 1991 in Helena.

A written copy of the proposed plan is available and written comments are still invited by writing to Bruce Desonia, AIDS/STD Program Manager, MDHES, Cogswell Building, Helena, Mt. 59620. The Department expects announcement of the award by April 1, 1991.

The services available under the grant are

- 1) Establish and operate HIV care consortia (of one or more public, one or more nonprofit private, health care and support service providers and community-based organizations) within areas most affected by HIV disease that shall be designed to provide a comprehensive continuum of care to individuals and families with HIV disease.

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- 2) Provide home-and community-based services for individuals with HIV disease. (Similar to the current award granted through 9/30/91, with the inclusion of appropriate mental health, developmental and rehabilitative services as an additional service available).
- 3) Provide assistance to assure the continuity of health insurance coverage for individuals with HIV disease (we must demonstrate the funds are targeted to individuals who would not otherwise be able to afford health insurance).
- 4) Provide treatments, that have been determined to prolong life or prevent serious deterioration of health, to individuals with HIV disease. (similar to our current AIDS Drug Reimbursement Program).

Syphilis Case Definition

Syphilis is a complex, sexually transmitted disease with a highly variable clinical course. Classification by a clinician with expertise in syphilis may take precedence over the following case definitions developed for surveillance purposes.

Primary Syphilis

Clinical description: The characteristic lesion of primary syphilis is the chancre, but atypical primary lesions may occur.

Laboratory criteria for diagnosis: Demonstration of *Treponema pallidum* in clinical specimens by darkfield, fluorescent antibody, or equivalent microscopic methods.

Case classification:

Probable: a clinically compatible case with one or more ulcers (chancres) consistent with primary syphilis and a reactive serologic test.

Confirmed: a clinically compatible case that is laboratory confirmed.

Secondary Syphilis

Clinical description: A stage of infection due to *Treponema pallidum*, characterized by localized or diffuse mucocutaneous lesions and generalized lymphadenopathy. Constitutional symptoms are common, and clinical manifestations are protean. The primary chancre may still be present.

Laboratory criteria for diagnosis: Demonstration of *T. pallidum* in clinical specimens by darkfield, fluorescent antibody, or equivalent microscopic methods.

Case classification:

Probable: a clinically compatible case with a reactive nontreponemal (VDRL, RPR) test titer of ≥ 4 .

Confirmed: a clinically compatible case that is laboratory confirmed.

Latent Syphilis

Clinical description: A stage of infection due to *Treponema pallidum* in which organisms persist in the body of the infected person without causing symptoms or signs. Latent syphilis is subdivided into early, late, and unknown syphilis categories based upon the length of elapsed time from initial infection.

Case classification:

Presumptive: no clinical signs or symptoms of syphilis and the presence of one of the following:

No past diagnosis of syphilis and a reactive nontreponemal test, and a reactive treponemal (fluorescent treponemal antibody-absorbed [FTA-ABS], microhemagglutination assay for antibody to *Treponema pallidum* [MHA-TP]) test.

A past history of syphilis therapy and a current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.

(STD case definitions taken from CDC's *Morbidity and Mortality Weekly Report*, Vol. 39, no. RR-13, October 19, 1990.)

Vaccine Orders

We would like to remind the clinics it's time to place your vaccine orders again for the next six months. The earlier we receive your order, on the correct order form, the earlier we can fill your order. If you have any questions in regards to your order, please call 444-5580.

MONTANA

RESIDENT AND NON-RESIDENT AIDS CASES¹

Acquired Immunodeficiency Syndrome (AIDS)

Definitive and Presumptive AIDS Cases

Surveillance Report - As of January 31, 1991

1. <u>Disease Category</u>	Adult/Adolescent/Pediatric	
	<u>Cases (%)</u>	<u>Deaths (%)</u>
PCP	34 (43)	26 (76)
Other Disease w/o PCP	44 (55)	25 (57)
KS Alone	2 (3)	0 (0)
<u>No Diseases Listed</u>	<u>0 (0)</u>	<u>0 (0)</u>
Total	80 (100)	51 (64)

2. <u>Age</u>	<u>Cases (%)</u>	3. <u>Race/Ethnicity</u>	Adult/Adolescent/Pediatric	
			<u>Cases (%)</u>	
Under 13	2 (3)	White, Not Hispanic	67 (84)	
13-19	1 (1)	Black, Not Hispanic	1 (1)	
20-29	24 (30)	Hispanic	3 (4)	
30-39	33 (41)	Native American	8 (10)	
40-49	13 (16)	<u>Unknown</u>	<u>1 (1)</u>	
Over 49	7 (9)	Total	80 (100)	
<u>Unknown</u>	<u>0 (0)</u>			
Total	80 (100)			

4. <u>Exposure Category</u>	Adult/Adolescent/Pediatric		
	<u>Males (%)</u>	<u>Females (%)</u>	<u>Total (%)</u>
Homosexual or Bisexual Men	47 (66)	0 (0)	47 (59)
Intravenous (IV) Drug User	8 (12)	1 (11)	9 (11)
Homo/Bi IV Drug User	9 (13)	0 (0)	9 (11)
Hemophiliac	3 (4)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (44)	4 (5)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (3)
Perinatal Transmission ²	1 (1)	1 (11)	2 (3)
<u>None of the Above/Other</u>	<u>3 (4)</u>	<u>1 (11)</u>	<u>4 (5)</u>
Total	71 (100)	9 (100)	80 (100)

Source: Montana AIDS/STD Program, MDHES, through January 31, 1991.

As of January 31, 1991 there have been 279 cumulative positive HIV tests from 24,361 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of December 31, 1990, 161,073 cases of AIDS and 100,813 deaths have been reported to the Centers for Disease Control.

Jan-1991.aid

¹Includes 60 Montana AIDS cases and 20 cases reported to Centers for Disease Control from other states who moved to Montana.

²Transmission from an infected mother to her fetus or infant during the perinatal period.

JANUARY 1991		Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Gierdise	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			4													
Big Horn			12				1								1	
Blaine			4	1				1						1		
Broadwater																
Carbon							1									
Carter																
Cascade			16		1		1							1		
Chouteau				1			1									
Custer			2					1						1		
Danilele																
Dawson			1		1											
Deer Lodge			1													
Fallon																
Fergus			1													
Flathead			1			2					1					
Gallatin			19	2	2			1						1		
Garfield																
Glacier			9				4			2						
Golden Valley																
Granite																
Hill			4													
Jefferson					1											
Judith Basin																
Lake			5											1		
Lewie & Clark			6					1								
Liberty				1												
Lincoln																
McCone																
Madison			1													
Meagher																
Mineral			1													
Missoula	1	12			4						1			3		
Museelahall																
Park			1									1		1		
Petroleum																
Phillips																
Pondera			1				4									
Powder River																
Powell			4													
Prairie																
Ravalli			4											1		
Richland																
Roosevelt			8		3									1		
Rosebud			2									1				
Sanders			1													
Sheridan													1			
Silver Bow			7	2												
Stillwater																
Sweet Grass																
Teton													1			
Toole			1													
Treasure																
Valley																
Wheatland														1		
Wibaux																
Yellowstone			24	2	2			4								
MONTHLY TOTAL	19 91	1	152	9	14	2	12	8	0	2	2	2	2	12	1	0
	19 90	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0
	19 89	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
TOTAL TO DATE	19 91	1	152	9	14	2	12	8	0	2	2	2	2	12	1	0
	19 90	1	133	8	12	2	3	3	0	0	2	15	3	5	2	0
	19 89	1	128	4	27	1	4	11	0	0	0	3	8	2	12	0
OTHER DISEASES:																
<u>ASEPTIC MEN:</u> Gallatin - 1 CHICKENPOX: Silverbow - 31																
<u>BAC MEN UNSPEC:</u> Yellowstone - 1 TULAREMIA: Ravalli - 1																

A two-part chronic disease epidemiology workshop will be held March 13-15, and May 15-17, 1991 at the Coach House East in Helena. The workshop is co-sponsored by the Montana Department of Health and Environmental Sciences, the Montana Medical Association, the University of Washington School of Public Health and Community Medicine and the Montana Area Health Education Center. Registration for the two-part course is \$25.

Targeted to state and local health program managers, the workshop is designed to provide the skills and knowledge needed to plan, implement and integrate programs to reduce chronic disease in Montana. The 4-day workshop will be most effective for those whose job responsibilities include making program and policy decisions based on surveillance data or allocating resources for chronic disease programs.

Faculty members include Steven Helgersen, MD, MPH; Mark W. Oberle, MD, MPH; Stephen Schwartz, PhD, MPH; and Todd Damrow, PhD, MPH. Todd Damrow, PhD, MPH, is the newly-assigned Montana state epidemiologist. Dr. Damrow was formerly a microbiologist and epidemiologist with the Washington Department of Health.

Dr. Helgersen is senior epidemiologist for the Indian Health Service and area epidemiologist for the Portland and Billings Indian Health Service Headquarters. He has 17 years of field experience in epidemiology and has contributed many research articles to the science of epidemiology.

Dr. Oberle is Assistant Dean for Public Health Practice, School of Public Health and Community Medicine, University of Washington. He previously was acting director for Science, Center for Health Promotion and Education at the Centers for Disease Control. He has both international and domestic experience in epidemiology.

Stephen M. Schwartz, PhD, MPH, is Assistant Professor of Epidemiology at the University of Washington. Dr. Schwartz also serves as affiliate investigator at the Fred

Hutchinson Cancer Research Center in Seattle. His primary research activity has focused on cancer epidemiology. He is presently involved in studies of adverse reproductive outcomes and cardiovascular disease.

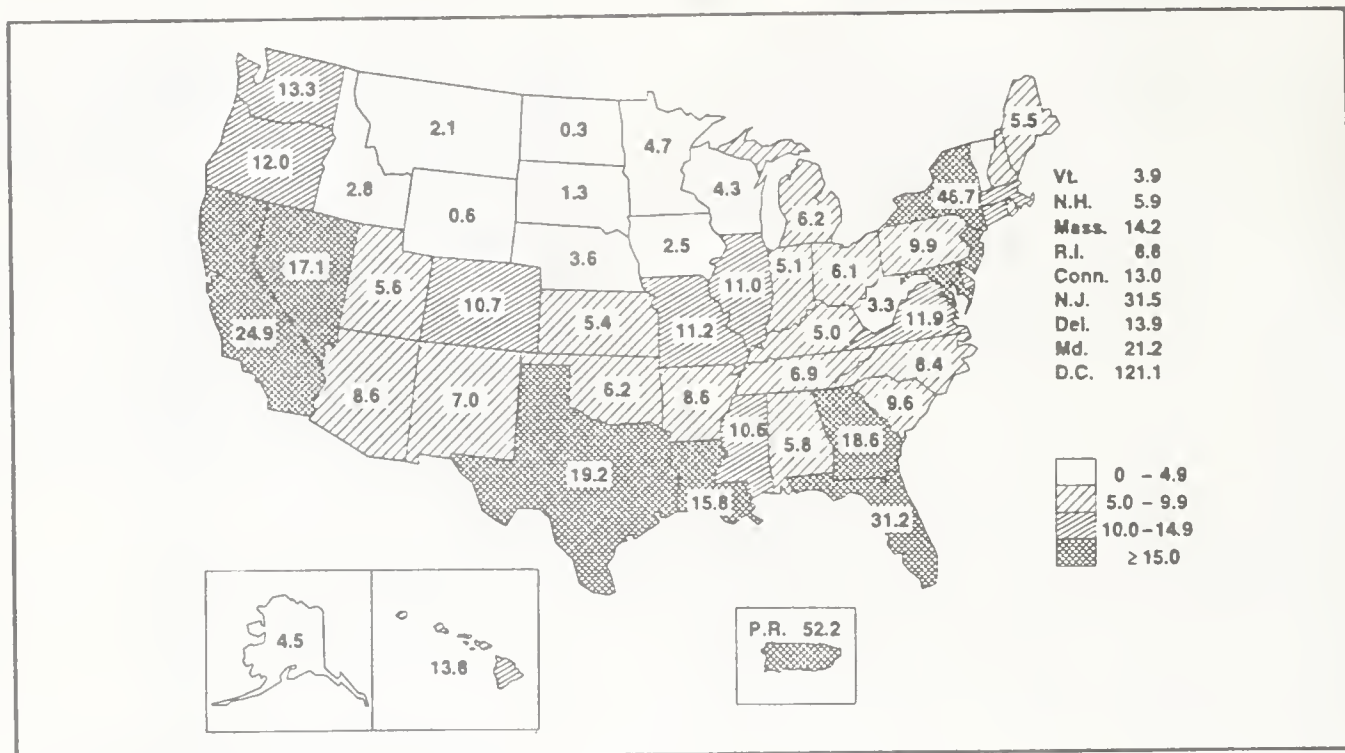
Applications have been submitted for continuing education credit for nurses and dietitians. MMA has approved 26 hours of CMEU's for full attendance at the 4-day workshop. For more information about the epidemiology workshop, contact Bob Moon at 444-4488 or Marsha McFarland at 444-2555.

Salmonellosis Surveillance

This is to alert you to a potential problem and ask you to increase surveillance for Salmonellosis for several months. We would also encourage you to obtain testing on diarrhea stools in patients who present with at least 2 days of diarrhea and other symptoms consistent with a bacterial infection, such as fever. We encourage laboratories to refer Salmonella isolates to the Montana Department of Health and Environmental Sciences Public Health Laboratory for further analysis.

After discussions with the Centers for Disease Control, we would also like to take this opportunity to remind you raw shell eggs are now considered a hazardous food. This means they must be refrigerated during storage and thoroughly cooked before eating to minimize the risk of transmission of pathogens, primarily Salmonella. The northeastern United State has been having a Salmonellosis outbreak for approximately 5 years and the source has been traced to shell eggs from infected flocks. Persons whose health is compromised by various conditions are at greater risk of developing Salmonellosis and subsequent severe sequelae such as sepsis.

AIDS cases per 100,000 population – United States, January–December 1990



Volume: 15:1

Month of: JANUARY, 1991

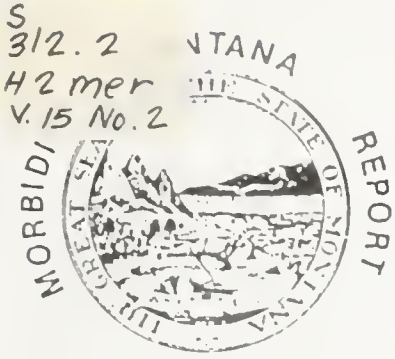
MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

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VOL. 15:2

February, 1991

Montana State Department of Health and Environmental Sciences

New Staff and Position Changes at MDHES AIDS/STD Program

Kathy Anderson has recently been promoted from Public Health Educator to the Program Officer. CONGRATULATIONS KATHY! Kathy can still be reached at 444-3566.

We also have a new administrative aide. Jeannie Thrush comes to our department from the Department of Revenue, Property Assessment Division. She is a Montana native who moved to Helena 4 1/2 years ago from her hometown of Missoula. She is a newlywed who loves to play the piano and ride horses. Welcome to the program!

Another change is that we have recently changed our phone system. Please do not use the 444-4740 number any longer. You may reach our program through 444-3565 (STD Program at 444-3949) or through the staff's extensions, which are as follows:

- Judy Gedrose 444-4748, Bureau Chief
- Bruce Desonia 444-2457, Program Manager
- Kathy Anderson 444-3566, Program Officer II
- Jim Murphy 444-4744, Health Officer I (Surveillance and ADRP)
- Amy E. Harris 444-2675, Public Health Educator (CBOs, CTS, etc)
- Karen Winden 444-2454, Administrative Assistant (Contract info.)
- Jeannie Thrush 444-3565, Administrative Aide (brochures, videos etc)
- Valinda Holmes 444-3949, Administrative Clerk
- Paul Lamphier 444-1604, Field Health Officer

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* HIV/AIDS INFORMATION *

Hotline Update!

The Montana Department of Health and Environmental Sciences AIDS Hotline has been updated! The AIDS Hotline is recorded messages on a variety of HIV-related issues. The changes to the hotline are not only new information but new categories as well. We have combined "How to Protect Yourself" and "How to Use a Condom Correctly," in order to make space for a section on Infection Control to prevent HIV and HBV exposure. This section will also be updated as soon as the CDC proposes it's new recommendations on preventing patient exposure from Health Care Workers with HIV. The MDHES AIDS Hotline's number is 1-800-233-MONT (6668). Other local Hotline numbers are: Out In Montana 1-800-336-4297 and for eastern Montana Yellowstone AIDS Project, 1-800-675-2437. The National AIDS Hotline is 1-800-342-2437.

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Case Definitions

(STD case definitions taken from CDC's Morbidity and Mortality Weekly Report, vol. 29, no. RR-13, October 19, 1990)

CHLAMYDIA TRACHOMATIS INFECTION

Clinical description: Infection with Chlamydia trachomatis may result in urethritis, epididymitis, cervicitis, acute salpingitis, or other syndromes when sexually transmitted. Perinatal infections may result in inclusion conjunctivitis and pneumonia among newborns. Other syndromes that can be caused by C. trachomatis include lymphogranuloma venereum (see Lymphogranuloma Venereum Infection) and trachoma.

Laboratory criteria for diagnosis:

Isolation of C. trachomatis by culture, or

Demonstration of C. trachomatis in a clinical specimen by antigen detection methods.

Case classification:

Confirmed: A case that is laboratory confirmed.

GENITAL HERPES (HERPES SIMPLEX VIRUS)

Clinical description: An illness characterized by visible, painful genital or anogenital lesions.

Laboratory criteria for diagnosis:

Isolation of herpes simplex virus from cervix, urethra or anogenital lesions, or

Demonstration of virus by antigen detection technique in clinical specimens from cervix, urethra, or anogenital lesion, or

Demonstration of multinucleated giant cells on a Tzanck smear of scrapings from an anogenital lesion.

Case classification:

Probable: A clinically compatible case (in which primary and secondary syphilis has been ruled out by serology and darkfield microscopy, when available) with either a diagnosis of genital herpes based on clinical presentation (without laboratory confirmation) or a history of one or more previous episodes of similar lesions.

Confirmed: A clinically compatible case that is laboratory confirmed.

Comment: Herpes should be reported only once per patient. The first diagnosis for a patient with no previous diagnosis should be reported.

GONORRHEA

Clinical description: A sexually transmitted infection commonly manifested by urethritis, cervicitis or salpingitis. Infection may be asymptomatic.

Laboratory criteria for diagnosis:

Isolation of Neisseria gonorrhoeae from a clinical specimen or

Observation of gram-negative intracellular diplococci in a urethral smear obtained from a man.

Case classification:

Probable: Demonstration of gram-negative intracellular diplococci in an endocervical smear obtained from a woman, or a written (morbidity) report of gonorrhea submitted by a physician.

Confirmed: A clinically compatible case that is laboratory confirmed.

MONTANA DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
 Acquired Immunodeficiency Syndrome (AIDS)
 Definitive and Presumptive AIDS Cases
 Surveillance Report - As of February 28, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	33 (41)	25 (76)	1 (50)	1 (100)	34 (41)	26 (76)
Other Disease w/o PCP	46 (58)	27 (59)	1 (50)	0 (0)	47 (57)	27 (57)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	80 (100)	52 (65)	2 (100)	1 (50)	82 (100)	53 (65)

2. Age		3. Race/Ethnicity	Adult/Adolescent	Pediatric	Total
Cases (%)			Cases (%)	Cases (%)	Cases (%)
Under 13	2 (2)	White, Not Hispanic	69 (86)	0 (0)	69 (86)
13-19	1 (1)	Black, Not Hispanic	1 (1)	0 (0)	1 (1)
20-29	26 (32)	Hispanic	3 (4)	0 (0)	3 (4)
30-39	33 (40)	Native American	6 (8)	2 (100)	8 (10)
40-49	13 (16)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	7 (9)	Total	80 (100)	2 (100)	82 (100)
Unknown	0 (0)				
Total	82 (100)				

4. Patient Groups	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	48 (67)	0 (0)	48 (60)
Intravenous (IV) Drug User	9 (13)	1 (13)	10 (13)
Homo/Bi IV Drug User	9 (13)	0 (0)	9 (11)
Hemophiliac	3 (4)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (50)	4 (5)
Transfusion With Blood/Products	0 (0)	2 (25)	2 (3)
None of the Above/Other	3 (4)	1 (13)	4 (5)
Total	72 (100)	8 (100)	80 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through February 28, 1991.

As of February 28, 1991 there have been 286 cumulative positive HIV tests from 24,893 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of January 31, 1991, 164,129 cases of AIDS and 102,803 deaths have been reported to the Centers for Disease Control.

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¹Includes 61 Montana AIDS cases and 21 cases reported to Centers for Disease Control from other states who moved to Montana.

FEBRUARY 1991	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		5	1	1		2	1	1							
Blaine		1													
Broadwater															
Carbon		1													
Carter															
Cascade		18		1			3						4		
Chouteau		1													
Custer		5													
Daniels	1														
Dawson	2	1													
Deer Lodge		2													
Fallon															
Fergus		2									1				
Flathead	2	6	1							1			1		
Gallatin		25	1				1						1		
Garfield															
Glacier		8				12									
Golden Valley															
Granite															
Hill		2													
Jefferson		1													
Judith Basin															
Lake		7											1		
Lewis & Clark	1	8	1				2								
Liberty			1												
Lincoln		1													
McCone															
Madison															
Meagher															
Mineral															
Missoula	1	18	1							1					
Musselshell															
Park		2													
Petroleum															
Phillips				1											
Pondera															
Powder River															
Powell		1		1	1										
Prairie															
Ravalli															
Richland	1														
Roosevelt		8	1	1											
Rosebud		4		1											
Sanders		1													
Sheridan															
Silver Bow		6											1		
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone		41	2	2			2					1	2		
1991	9	173	9	8	1	13	9	1	0	1	2	1	10	0	0
1990	1	126	11	17	1	15	12	1	1	1	2	4	5	3	0
1989	6	120	11	18	0	4	1	1	0	0	7	4	12	23	0
1991	10	330	18	22	3	25	17	1	2	2	4	3	22	1	1
1990	2	259	19	29	3	18	15	1	1	3	17	7	10	5	0
1989	7	248	15	45	1	8	12	1	0	0	10	12	14	25	2
OTHER DISEASES:	CHICKENPOX: Lewis & Clark - 10 Judith Basin - 7 Yellowstone - 5 Cascade - 4 Gallatin - 2 BACT. MEN UNSPEC: Gallatin - 1 YEPHSINTOSIS: Flathead - 1 SYPHILIS: Richland - 1														

LEGIONELLOSIS ASSOCIATED WITH HOT TUB?

On Thursday, March 7, 1991, the Preventive Health Services Bureau was notified of four cases of Pontiac fever among a group of tourists returning to Louisiana from a Montana ski resort. The four cases were characterized by a rapid onset of fever, headache, malaise, myalgia, and a non-productive cough. These symptoms developed in all of the subjects within a 24 hour period. All of the subjects reported using the same hot tub in one of the rental units at the resort during the previous week. Hot tub use was the only common exposure identified among the cases.

Health care providers in the areas were contacted in attempt to uncover additional cases. Also, the property manager of the site, upon request, provided a listing of all recent tenants of the units occupied by the affected parties. All attempts to find additional cases were unsuccessful.

Serologic tests on convalescent phase sera from the subjects showed antibody activity to Legionella pneumophila by EIA. Subsequent testing of these specimens at CDC using a fluorescent antibody technique revealed findings which were not inconsistent with the diagnosis of legionellosis or Pontiac fever.

The subjects reported that the "chlorine basket" of the hot tub was empty at the time of their use, and that they were suspicious that the tub might be not be adequately chlorinated. Water samples were not available to test for adequate levels of disinfectant, or for heavy contamination with Legionella. The hot tub purportedly had been properly maintained and serviced under contract with a whirlpool/spa maintenance firm. Other possible sources of drift aerosols, such as decorative fountains, evaporative condensers, cooling towers or other heat exchangers were not identified in the area.

Currently, there is not evidence of a continuing problem at the exposure site. If this cluster of cases was caused by Legionella from the suspect hot tub, it is felt to have been an isolated incident, possible due to a maintenance breakdown, which has since been corrected. Additional cases are not expected.

While hot tubs are generally not recognized as a common source of Legionella, cases of non-pneumonic legionellosis (Pontiac fever) have been reported in association with the use of whirlpool spas where disinfection was not adequate. Inadequate disinfectant levels in hot tubs and whirlpool spas are most often associated with rash illnesses, commonly Pseudomonas folliculitis.

Routine maintenance and inspection of whirlpool spas (in particular, commercial spa facilities) is important. The following points should be considered:

- Chlorine is a better disinfecting agent against legionellae than bromine. A continuous in-line chlorinator should be considered in lieu of a system utilizing bromine.
- Disinfection systems should be of the in-line type, and in continuous operation in order to allow the system to adequately disinfect.
- Disinfectant levels should be checked frequently and recorded.

NEW STATE EPIDEMIOLOGIST ANNOUNCED

The Montana Department of Health & Environmental Sciences, Preventive Health Services Bureau, announces the hiring of Todd Damrow. Ph.D., M.P.H., as the State's new epidemiologist. He assumed his duties on February 25, 1991. This position was formerly held by Judith Gedrose who was promoted within the department. Todd comes to the department from Seattle where he was employed as an epidemiologist and microbiologist for the Washington State Department of Health. He is looking forward to working together with health care professionals in Montana. He can be contacted at phone (406) 444-3986.

REMINDER

The annual conference of the Montana Public Health Association is scheduled for April 10-12 at the Colonial Inn in Helena. The theme for this years' conference is PARTNERS IN PUBLIC HEALTH. Questions regarding the MPHA conference should be directed to the MSU Office of Continuing Education at (406) 994-4930.

Volume: 15

Month of: FEBRUARY, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

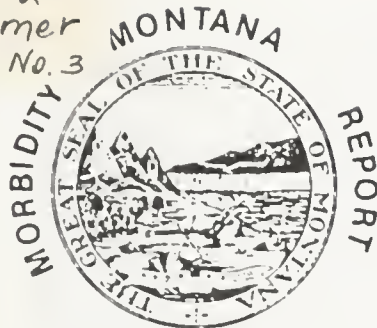
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VOL. 15 NO. 3

MARCH, 1991

Montana State Department of Health and Environmental Sciences

TICK SEASON APPROACHES

PLEASE RETURN
INDEX

Along with the approaching mild weather, ticks begin to appear. In Montana, people began noting ticks during the mild days of mid-March. Ticks are most numerous in wooded or brushy areas frequented by animals. Species of ticks in Montana have been associated with the transmission of Rocky Mountain spotted fever, Colorado tick fever, relapsing fever, tularemia, Q-fever and tick paralysis. Notably absent from the list of tick-borne diseases in Montana is Lyme disease. While ticks are abundant throughout the state, species of ticks capable of transmitting Lyme disease have never been detected feeding on man. Species of ticks in this state are primarily Dermacentor andersoni (the Rocky Mountain wood tick) and D. variabilis (the dog tick). Neither specie has been shown by researchers to be a competent vector of Lyme disease. Health care workers, however, should continue to suspect Lyme disease among subjects with a history of travel to the endemic areas of the northeast, mid-west and the Pacific Coast.

Persons entering tick infested areas should be encouraged to wear light-colored clothing to facilitate detection of ticks, and to wear long pants tucked into ones socks. Insect repellants are of dubious value in protecting against tick bites (ticks are not insects). One should

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periodically examine themself for the presence of ticks, especially in the hairline, armpit and groin regions. Ticks typically crawl around on a person for an hour or longer searching for a suitable place to attach. To remove embedded ticks, grasp them as close to the skin surface as possible with tweezers or protected fingers, and gently pull backwards with a slow, steady pull. Persons sustaining a tick bite should contact their physician if becoming ill following the exposure, and notify their doctor of the bite.

 * HIV/AIDS INFORMATION *

RYAN WHITE-TITLE II
FUNDS AWARDED!

The Montana Department of Health and Environmental Sciences AIDS/STD Program has been awarded \$100,000 under the Ryan White Comprehensive AIDS Emergency Resources (CARE) Act, Title II of 1990. The intent of the grant is to improve the quality, availability and organization of health care and support services for individuals with HIV infection.

The \$100,000 will fund the HIV Care Consortia, Continuum of Health Insurance Coverage and Provision of Treatment components of the grant. Provision of Home and Community-Based Care will continue through a current, but separate Home-Based Services Grant.

The HIV Care Consortia will receive the majority of the funding -\$60,000. The number of consortia funded will depend upon the number of successful applicants to the Request for Proposal. Each consortium will be based in an area of high incidence. Services and activities offered will vary by region, but emphasis will be placed on case management and utilization of existing services. An estimated 40-60 individuals will be served through the consortia.

The Request for Proposal for the HIV Care Consortia was released on April 10, 1991. RFPs were sent to all county commissioners as well as the Counseling, Testing, Referral and Partner Notification (CTRPN) sites and Community Based Organizations (CBO). Any other groups interested can contact the AIDS/STD Program at 444-3565. The deadline for application is May 10, 1991.

Five thousand dollars has been budgeted for the Continuum of Health Insurance Coverage. The intent of this component is to provide continued coverage for qualified individuals who are currently insured through their employer. DHES will coordinate with SRS and serve an estimated three to seven people.

The \$30,000 budgeted for the Provision of Treatment component will fund the existing ADRP (AIDS Drug Reimbursement Program). Zidovudine will be provided to qualified individuals. As alternative drugs are approved, DHES will investigate the costs and number of clients who may benefit. Twenty to 30 people will be served through this program.

Title II is the first component of the Ryan White Act to impact Montana. In 1992, Title III will be put into place. Title III will require early intervention services for the individual infected with HIV. Montana is getting a head start with this legislation and is implementing its Early Intervention Program in July. Watch for further information in future Montana Morbidity Reports.

MONTANA AIDS RESOURCE DIRECTORY

The AIDS/STD Program is currently updating it's AIDS Resource Directory. If you would like to be added to the Montana AIDS Resource Directory, have any changes, or have a more efficient directory you use which could be incorporated into the updated directory, please let us know. The AIDS Resource Directory is also available on-line through AHEC's Healthcon system. We also solicit any comments on how to improve this directory. Please refer information regarding the directory to Amy E. Harris, at the Montana Department of Health and Environmental Sciences, (406) 444-2675.

MEASLES ADVISORY

Washington State health officials recently notified the Montana Department of Health and Environmental Sciences of an outbreak of 15 cases (as of April 10) of measles in a northeastern Washington county. The cases occurred among people who make and sell crafts at regional barter fairs. Montanan's attending such fairs in the area are likely to be at increased risk of exposure.

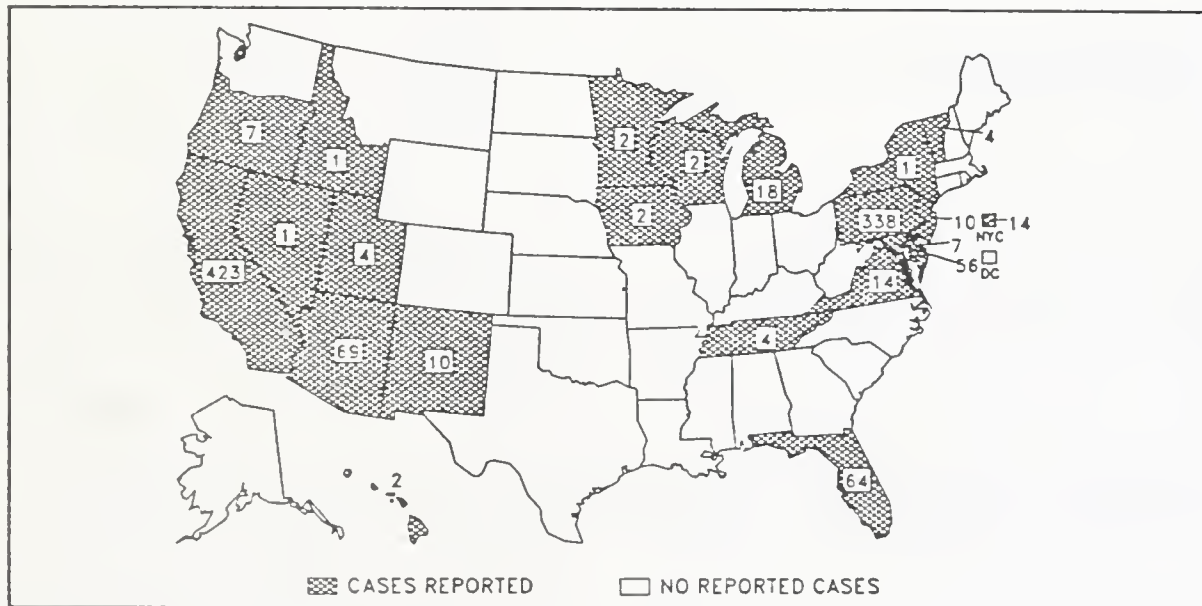
Cases of measles are occurring at elevated levels in several other areas as shown on the map below. The map is for March 3-30, and from MMWR of April 5, 1991. As the time approaches when out-of-state travel increases, and out-of-state visitors are more common, it is suggested that county and local health care providers re-emphasize the importance of measles vaccination. The recently revised measles recommendations of CDC's Immunization Practices Advisory Committee are for 2 doses for all persons born after 1957 who are not immune. Persons with only one prior dose are not considered immune to measles. In temperate climates, cases of measles occur primarily in late Winter and early Spring.

RURAL NURSES - 2nd ANNUAL SUMMER INSTITUTE

The Intercollegiate Center for Nursing Education (ICNE) is providing an opportunity for rural nurses to join in a variety of educational activities on June 17-20, 1991, in Spokane, WA. Classes will include: physical assessment; pediatric assessment; pharmacology update; trauma update; care for the caregiver; legislative mandates; preparing to care for AIDS patients; assertiveness; time management; assigning and supervising staff; improving charting and documentation; computer applications for decision-making; conducting performance evaluations; and others.

A complete brochure will be available by writing the ICNE at 2917 West Fort George Wright Drive, Spokane, WA, 99204-5298, or by calling at (509) 325 6146 or 326-7270.

Reported cases of measles, by state – United States, weeks 10–13, 1991



MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of March 31, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	33 (40)	25 (76)	1 (50)	1 (100)	34 (41)	26 (76)
Other Disease w/o PCP	48 (59)	28 (58)	1 (50)	0 (0)	49 (58)	28 (57)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	82 (100)	53 (65)	2 (100)	1 (50)	84 (100)	54 (64)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	71 (87)	0 (0)	71 (85)
13-19	1 (1)	Black, Not Hispanic	1 (1)	0 (0)	1 (1)
20-29	26 (31)	Hispanic	3 (4)	0 (0)	3 (4)
30-39	34 (40)	Native American	6 (7)	2 (100)	8 (10)
40-49	14 (17)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	7 (8)	Total	82 (100)	2 (100)	84 (100)
Unknown	0 (0)				
Total	84 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	50 (68)	0 (0)	50 (61)
Intravenous (IV) Drug User	9 (12)	1 (13)	10 (12)
Homo/Bi IV Drug User	9 (12)	0 (0)	9 (11)
Hemophiliac	3 (4)	0 (0)	3 (4)
Heterosexual Contact	0 (0)	4 (50)	4 (5)
Transfusion With Blood/Products	0 (0)	2 (25)	2 (2)
None of the Above/Other	3 (4)	1 (13)	4 (5)
Total	74 (100)	8 (100)	82 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through March 31, 1991.

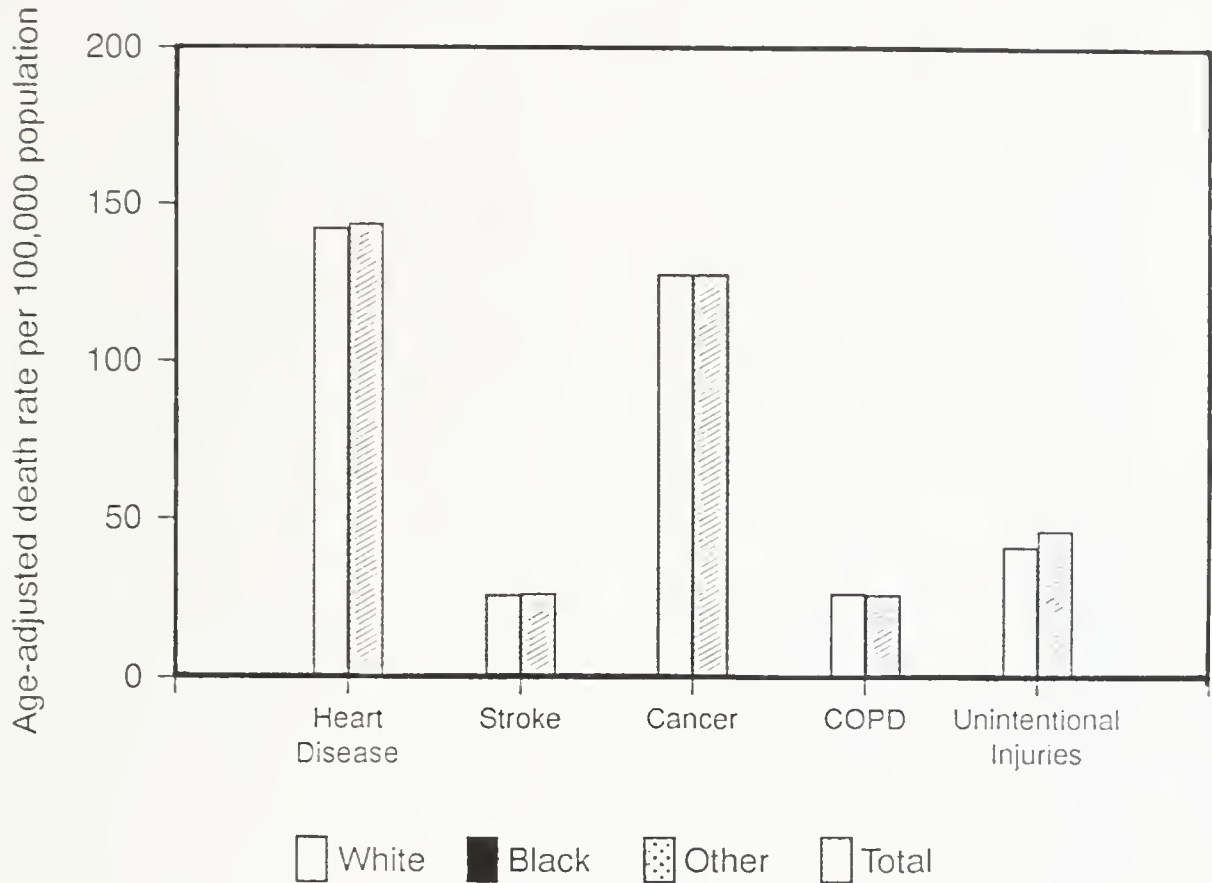
As of March 31, 1991 there have been 291 cumulative positive HIV tests from 25,534 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of February 28, 1991, 167,803 cases of AIDS and 106,361 deaths have been reported to the Centers for Disease Control.

March-1991

¹Includes 63 Montana AIDS cases and 21 cases reported to Centers for Disease Control from other states who moved to Montana.

Leading Causes of Death Montana, 1986-1988



Source: Centers for Disease Control

Supply Orders Now Being Filled

Supplies are now available of the revised "Certificate of Immunization" (ES 101-Revised 3/91) to be used for day care and school records. Please order for all schools in your district.

Also available are supplies of the newly revised clinic card (with spacing for signatures of both parents and person administering). The bifold wallet card, Official Montana Immunization Record, is

also still available and orders for any of the above 3 documents are welcome -- phone Liz at 444-5580 or request with your monthly vaccine report.

If your order is large, it may be necessary to fill it partially and ship the balance when the next printing order is received.

Please do not order more than this year's needs, as revisions may occur later in the year.

6.

UPCOMING EVENTS

April 20 - The Highs and Lows of Diabetes. Colonial Inn in Helena from 8:30 a.m. to 4:00 p.m. program funded by the Montana Department of Health and Environmental Sciences, Chronic Disease Prevention and Health Promotion Program. contact the American Diabetes Association, Montana Affiliate, Box 2411, Great Falls, MT 59403, (406) 761-0908 or 1-800-232-6668.

May 15-17 - Chronic Disease Epidemiology Workshop: A Public Health Approach. Coach House East, Helena, MT. Sponsored by Montana Dept. Health & Environmental Sciences, University of Washington School of Public Health and Community Medicine, U.S. Indian Health Service, and the MT Area Health Education Center. Contact Marsha McFarland, (406) 444-2555.

May 20 - AIDS Review Panel meeting - CTRPN/HERR sites and CBOs, please have material wanting to be reviewed in by May 13th to Amy E. Harris, MDHES STD/AIDS Program, Cogswell Building, Helena, MT 59620 or call 444-26785. The meeting is scheduled from 9:30 a.m. to 3:00 p.m. at the Cogswell Building, Room C209, side B, in Helena.

June 17-20 - Rural Nurses Summer Institute. Intercollegiate Center for Nursing Education, 2917 W. Fort George Wright Drive, Spokane, WA. For more info, call (509) 325-6146 or 326-7270.

June 18-20 - Interviewing/Field Investigation Course. Montana Dept. of Health and Environmental Sciences, Preventive Health Services Bureau, C209 Cogswell Building, Helena, MT. Contact Pam Brewster, (406) 444-2737.

June 19-23 - Rocky Mountain Health Promotion, 7th Annual conference, MSU Campus, Bozeman, MT. A cooperative Montana-Wyoming regional health conference designed to promote personal wellness and worksite wellness in the public and private sectors. (406) 994-4930.

June 26-27 - HIV Counselling Techniques Course. Billings, MT. Sponsored by Montana Department of Health and Environmental Sciences, AIDS/STD Program. Contact Amy Harris, (406) 444-2675.

WHAT'S HAPPENING IN YOUR COMMUNITY?

Are you doing a project, activity or study locally that's great, wonderful or exciting? If you are, let us know so that we can pass it on! Each month we would like to feature an activity, project or study that is being done in our state. Don't keep your good work to yourself! Please refer all materials or articles to Amy E. Harris, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, MT, 59601, or call (406) 444-2675.

Preventive Health Services Bureau Interviewing Course

Preventive Health Services Bureau is preparing for the 4th annual interviewing/field investigation course. It will be held June 18, 19 and 20 in Room C209, Cogswell Building, Helena, Montana. The course is designed for public health workers doing any kind of patient interaction or interviewing. We are expanding the course to try to make it applicable to situations where workers are intervening in chronic diseases as well as traditional communicable diseases. The course begins mid-morning on the first day and ends at noon on the third day in hopes this will allow more people to attend because travel costs would be less. Some of the objectives of the course are as follows:

1. Identify the qualities of the good investigator;
2. Describe how diseases are transmitted for those which an interview should occur;
3. Understand how to manage a case and do referrals for persons who are outside of your jurisdiction;
4. List five sources for locating information prior to beginning an investigation.

The course is a combination of didactic presentations and participant and course manager interaction. Persons planning to attend the course are asked to phone Pam Brewster at 444-2737 to allow us to prepare the appropriate number of handouts.

The Highs and Lows of Diabetes

"The Highs and Lows of Diabetes," a seminar for people with diabetes, their friends and family members, and health professionals will be held April 20, 1991, at the Colonial Inn in Helena from 8:30 a.m. to 4 p.m. This program has been funded by a grant from the Montana Department of Health and Environmental Sciences, Chronic Disease Prevention and Health Promotion Program.

Paul Fredlund, M.D., of Virginia Mason Diabetes Center in Seattle, Washington will present, "Staying Well Now...For the Future." Other sessions will include:

Parenting Children with Diabetes
Label-Reading, Low-Fat Eating and Cholesterol
Exercise and Diabetes
Diabetes and Over-the-Counter Drugs
Psychosocial Issues Facing the Person With Diabetes

A multi-disciplinary instructional approach will include a dietitian, pharmacist, nurse, licensed counselor and physical therapist.

There is no registration fee, however, participants will be charged \$12 for the cost of lunch. Continuing education credits will be available in some professional areas.

For further information contact: American Diabetes Association, Montana Affiliate, Box 2411, Great Falls, 59403, 761-0908 or 1-800-232-6668.

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Month of: March, 1991

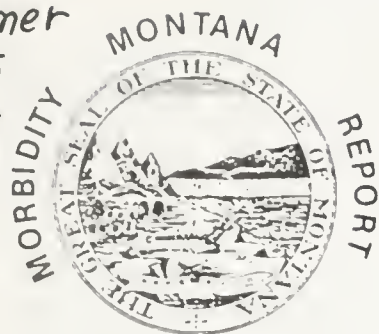
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APRIL, 1991

Montana State Department of Health and Environmental Sciences

INVASIVE HIB DISEASE

Haemophilus influenzae type b (Hib) is the leading cause of invasive bacterial disease among children. It typically presents as meningitis. About 12,000 cases of Hib meningitis are recorded in the United States each year. The disease is especially serious in children less than 5 years old. About 1 child in every 20 with meningitis caused by Hib disease dies of it, and about 1 out of 4 suffer permanent damage, ranging from mild hearing loss to mental retardation. Invasive Hib disease is preventable through vaccination. The Montana Department of Health and Environmental Sciences, Preventive Health Bureau, has placed a high priority on the prevention of Hib disease in Montana's children.

FDA Approves Hib Vaccine for Infants

Most cases of Hib disease occurs in children <15 months of age; a group for which a vaccine has not previously been available. Early vaccines against Hib were poorly immunogenic in <15 month old infants, and were licensed for administration only to children over 15 months of age. The FDA, however, has recently approved two vaccines which can be safely and effectively administered to infants as young as two months old. These "improved" vaccines, were developed by conjugating (chemically coupling) a highly immunogenic protein to the old Hib vaccine antigen. The linkage of this protein stimulates the immune response to Hib, and overcomes the inefficient characteristic of the old vaccine. The new vaccines are, thus, aptly termed Hib conjugate vaccines. The two Hib

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conjugate vaccines recently licensed for use with infants are 1) "HibTITER", manufactured by Praxis Biologics, Inc., and 2) "PedvaxHIB", manufactured by Merck, Sharp and Dohme. It should be noted that these vaccines have different schedules for administration.

New Immunization Guidelines Issued

The Montana Department of Health and Environmental Sciences, Immunization Program has released an update on guidelines for immunization against Hib infection. Based on guidelines of other states, and on recommendations of ACIP, the document has been developed for use in immunization clinics, local health departments, and physician offices. This material 1) describes the currently licensed vaccines, 2) summarizes available information about Hib conjugate vaccines, 3) offers guidelines for use of these vaccines in infants, and 4) advises how to use conjugate vaccines for older children. The document has been mailed to immunization clinics and local health officers. Additional copies are available on request by calling the Immunization Program office at 444-5580.

INFLUENZA - MONTANA, 1990-91 SEASON

The first isolates of influenza virus for the 1990-91 season in Montana were reported in January, 1991. The total case count for this season was 110; eight percent below the recent 3 year average.

Viral surveillance showed that influenza B was the predominant strain over influenza A at a ratio of 6:1. Activity was widespread, but mild, throughout the season. Cases occurred sporadically, or in small clusters. No outbreaks were reported.

Montana's influenza surveillance system relies primarily on the results of specimens submitted to the State's Public Health Laboratories. The recent isolate of an influenza A virus in late April suggests that the season may be expected to continue into mid-May.

ASSESSMENT GUIDE AVAILABLE FOR LOCAL HEALTH DEPARTMENTS

The National Association of County Health Officials (NACHO) in collaboration with CDC, American Public Health Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, and U.S. Conference of Local Health Officers, has developed the **Assessment Protocol for Excellence in Public Health**. This document is designed for use by local health departments to 1) assess and improve the organization of their departments, and 2) assist local communities in assessing and improving the health status of their residents. One copy is available free of charge to local health departments from NACHO, 440 First Street, N.W., Suite 500, Washington, DC 20001. The document is available to other organizations and persons for \$20.00 per copy.

NEWS ON CHOLERA

An epidemic of cholera is occurring in several South American countries. According to recent figures, over 150,000 cases and 1300 deaths in this region have been reported. Outbreaks of cholera are also occurring in Iraq and Bangladesh. There is potential for spread to other countries. Since cholera is associated with areas of poor sanitation, the risk of cholera in travelers who follow the normal tourist itineraries is very low. Nevertheless, U.S. residents traveling in these areas have become infected. The disease is transmitted through contaminated food and water. The usual precautions to avoid traveler's diarrhea should be closely observed. It is particularly important to avoid raw seafood, and to drink only treated water (e.g., by adding iodine or by boiling). The risk for secondary transmission of cholera in the U.S. is extremely small. Current vaccines for cholera confer only brief and incomplete protection, and are not recommended. There are no cholera vaccine requirements for entry or exit into most countries including the United States.

INTERNATIONAL TRAVELERS' HOTLINE

The Centers for Disease Control now has a 24-hour automated telephone system that provides information for international travelers on vaccine requirements and recommendations by geographic area. Menu options include information on malaria, food and water precautions, travelers' diarrhea, immunizations for children, pregnant travelers, and disease outbreaks. Additionally, answers to questions on clinical management is available to physicians and medical personnel. To access this information, dial (404) 332-4559. Callers can select any one or all of the informational messages by following the instruction which are given. The information is updated as needed.

MEASLES ALERT

The Montana Department of Health and Environmental Sciences has been alerted to a measles outbreak occurring in the south-eastern part of Idaho. As of May 9th, forty measles cases have been reported. Most of the cases have occurred in students at Ricks Community College in Rexburg, Idaho. It is known that measles has spread from the college students to middle and high school students in the outbreak area, to Idaho State University, and to residents in other parts of the state of Idaho.

The Department is concerned about the spread of measles among Montana residents, as students and other persons from the area of the outbreak may transmit the infection to unimmunized persons here.

On May 10, the Department issued a state-wide news release expressing concern about the possible spread of measles in Montana. The Department recommendations included: "People who may be exposed to measles should be sure they are immune to the disease. Persons who have not received 2 doses of measles vaccine (MMR) are not considered immune. People born before January 1, 1957 are generally considered immune to measles and do not require additional measles vaccination. Children younger than 15 months of age are not immune. Persons who are unsure of their immune status should contact their private physician or local health department."

The Department requests health care providers and school personnel to maintain a high suspicion of measles. All measles cases, including "suspect" cases should be reported immediately to the local health department or to the Montana Immunization Program (444-5580).

CHANGES IN GOVERNMENT HEALTH CARE INFORMATION ACT MADE IN LEGISLATURE

Senate Bill 336, introduced by Senator Bob Pipinich, clarifies some confusion regarding the release of health care information by local health departments.

The Uniform Health Care Information Act of 1987 set strict rules governing the release of health care information by providers (eg., physicians, nurses). However, health departments frequently acquire health information without being the providers of the care. Thus, departments were without legal standards governing the circumstances under which they could release the health care information in their possession. Therefore, in 1989, the Government Health Care Information Act was passed into law, and addressed the release of health information by public health officials. The unforeseen problem was that some workers are, both, personal health care providers and public health officials. Senate Bill 336 adds a new section to the Uniform Health Care Information Act to provide rules to follow whenever a local health department is uncertain which law applies. As soon as the work of the legislature is codified, the content of SB 336 will be found in the Uniform Health Care Information Act, Title 50, Chapter 16, Part 6.

What's Happening in Your Community?

Out In Montana (OIM) has been busy over the last several months. In February OIM put together the 1991 Montana Gay Health Conference in Helena, which was attended by over 25 men and women from around Montana. They received education on the special health and social needs of lesbians and gay men. The highlights of the conference were the speakers brought in from other states; Michael De Mayo from the Gay Men's Health Crisis and Bruce Meyers, from the University of Minneapolis, Duluth, representing the American College Health Association.

In the weeks following the conference OIM moved their office to Missoula in hopes that the move would help to increase the number of volunteers to work with OIM. They have maintained the same toll-free number (1-800-366-4297) but we have a new local number - 542-6601.

If you are interested in any of the services provided by Out In Montana, you may contact Steve Simpson at the above numbers between 11:00 and 5:00 or write to OIM, P. O. Box 8661, Missoula, MT 59801-8661.

PHS BUREAU PHONE LISTING UPDATE

There have been several personnel and phone number changes in the Preventive Health Services Bureau. The following updated list was prepared for your convenience to assist you in receiving more efficient service. Please note that the answering service is now available only after hours.

MONTANA DEPARTMENT OF HEALTH AND
ENVIRONMENTAL SCIENCES
HEALTH SERVICES DIVISION
8 am - 12 noon & 1 pm - 5 pm
Monday - Friday
Telephone Numbers [prefix - 444]

PREVENTIVE HEALTH SERVICES BUREAU . . . 2737
After hours, emergency . . . 4740
Judith Gedrose, Bureau Chief. . . 4748
Pam Brewster. 2737

AIDS/STD. 3565
Hotline 1-800-233-6668
Bruce Desonia, Program Manager. . 2457
Karen Winden. 2454
Jeannie Thrush. 3565
James Murphy. 4744
Amy Harris. 2675
Claudia Montagne. 3566

STD 3949
Kathy Andersen, Program Officer . 2678
Paul Lamphier 1604
Valinda (Val) Holmes. 3949

CHRONIC DISEASE/HEALTH PROMOTION. . . 2640
Bob Moon, Program Manager . . . 4488
Marsha McFarland. 2555
Cecilia Cowie 2672
Jane Smilie 2640

EPIDEMIOLOGY

Todd Damrow, Ph.D.

State Epidemiologist 3986

IMMUNIZATION/FIELD HEALTH OFFICERS. . 5580

Dick Paulsen, Program Manager . . 3624
Deborah Schneider 3621
Stan Strom. 2969
Mark Peacock. 3629
Joyce Burgett, R.N. 1805
Elizabeth Thaggard. 5580

Answering service for after hours
rabies consultation remains 4740

UPCOMING EVENTS

May 15-17 **Chronic Disease Epidemiology Workshop: A Public Health Approach.** Coach House East, Helena, MT. Sponsored by Montana Dept. Health & Env. Sciences, University of Washington School of Public Health and Community Medicine, U.S. Indian Health Service, and the MT Area Health Education Center. Contact Marsha McFarland, (406) 444-2555.

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June 27-28 **HIV Counselling Techniques Course.** Billings, MT. Sponsored by Montana Department of Health and Environmental Sciences, AIDS/STD Program. Contact Amy Harris, (406) 444-2675

NEW AIDS CASE REPORT FORM

Reporting of HIV and AIDS is required by state law, yet many physicians and nurses are unaware of the how and what to report. General information such as how to report and the differences in HIV and AIDS reports are outlined below and can be found in rule 16, chapter 28, sub-chapters 201 through 204 of the Administrative Rules.

In the case of HIV infection, or potential AIDS, a report has to be made to the state health department only. All that is required is the date of the HIV test, the name and address of the **reporter**, and an initial or number assigned by the reporter to the subject. The name of the subject is **not** required. Such case reports may be submitted on the yellow case cards currently used for other reportable communicable diseases. If the HIV test was performed or confirmed by the State Public Health Laboratory this report is optional.

In the event of an AIDS diagnosis, the report should be made to the local county health officer, who then notifies the state of the case. The required information would include the name and age of the case, information relating to the diagnosis, name of the physician, and the name of the reporter. Completion of the case report and ensuring the notification of contacts would be a joint effort between the state and the county. In some instances the case report may be sent directly to the state health department. In most cases the state department then notifies the local county health department of the case. In addition to the case report developed by CDC an alternate form has been developed by our office. This form is attached to this month's morbidity report. We hope that the new form is more simple to complete and provides more information on the reporting of cases. In addition the form is much easier to distribute or copied for your use.

While anyone may report a suspected case of a communicable disease to the health department our program relies heavily on the physician for case reports. This enables us to receive the case report as soon as possible and enhances our depart-

ment's communication with health care providers.

All information is strictly confidential and is shared only with the county health officer or his designee. Statistical information is printed monthly in the Montana Morbidity Report and sent to the Centers for Disease Control (CDC). Patient names and those of physicians are not sent to CDC.

If you need any further information on HIV/AIDS reporting please call Jim Murphy, Surveillance Coordinator, at 444-4744 and I would be happy to provide it. Thank you for your cooperation.

AIDS/STD PROGRAM WELCOMES NEW STAFF MEMBER

Claudia Montagne recently joined the Montana AIDS Program as a Public Health Educator. She has replaced Kathy Andersen who has been moved up to the Program Officer position. Claudia comes to the program with an extensive background in health. She received her degree in Microbiology at the University of California and has worked at Shodair Hospital as a certified chemical dependency counselor in the position of Admissions Coordinator. She has also worked closely with the Lewis and Clark AIDS Project since it's beginnings and received the Governor's Award for her outstanding work with them. She also serves on the Lewis and Clark City-County Health Board. WELCOME ABOARD CLAUDIA! Claudia can be reached at 444-3566.

CORRECTION!

June 26-27 HIV Counseling Techniques Course has been rescheduled for June 27-28 1991.

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of April 30, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	34 (40)	26 (76)	1 (50)	1 (100)	35 (40)	27 (77)
Other Disease w/o PCP	51 (59)	29 (57)	1 (50)	0 (0)	52 (59)	29 (56)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
<u>No Diseases Listed</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>
Total	86 (100)	55 (64)	2 (100)	1 (50)	88 (100)	56 (64)

2. Age		3. Race/Ethnicity	Adult/Adolescent	Pediatric	Total
Cases (%)	Cases (%)		Cases (%)	Cases (%)	
Under 13	2 (2)	White, Not Hispanic	75 (87)	0 (0)	75 (85)
13-19	2 (2)	Black, Not Hispanic	1 (1)	0 (0)	1 (1)
20-29	27 (31)	Hispanic	3 (3)	0 (0)	3 (3)
30-39	35 (40)	Native American	6 (7)	2 (100)	8 (9)
40-49	15 (17)	<u>Unknown</u>	<u>1 (1)</u>	<u>0 (0)</u>	<u>1 (1)</u>
Over 49	7 (8)	Total	86 (100)	2 (100)	88 (100)
<u>Unknown</u>	<u>0 (0)</u>				
Total	88 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	52 (67)	0 (0)	52 (60)
Intravenous (IV) Drug User	10 (13)	1 (13)	11 (13)
Homo/Bi IV Drug User	9 (12)	0 (0)	9 (10)
Hemophiliac	4 (5)	0 (0)	4 (5)
Heterosexual Contact	0 (0)	4 (50)	4 (5)
Transfusion With Blood/Products	0 (0)	2 (25)	2 (2)
<u>None of the Above/Other</u>	<u>3 (4)</u>	<u>1 (13)</u>	<u>4 (5)</u>
Total	78 (100)	8 (100)	86 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
<u>None of the above/Other</u>	<u>0 (0)</u>	<u>0 (0)</u>	<u>0 (0)</u>
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through April 30, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of April 30, 1991 there have been 294 cumulative positive HIV tests from 26,023 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of March 31, 1991, 171,876 cases of AIDS and 108,731 deaths have been reported to the Centers for Disease Control.

March-1991

¹Includes 66 Montana AIDS cases and 22 cases reported to Centers for Disease Control from other states who moved to Montana.

AIDS ADULT CONFIDENTIAL CASE REPORT

Soundex _____ Stateno. _____

Montana Department of Health and Environmental Sciences; Montana AIDS Program; Cogswell Bldg; Helena, Mt. 59620

PATIENT NAME: _____

BIRTHDATE: _____ SEX ☐ Male ☐ Female

RACE : ☐ White ☐ Amer Indian ☐ Other: _____

COUNTY OF RESIDENCE AT Dx: _____

STREET _____

CITY _____ ZIP CODE _____

STATUS: ☐ Alive ☐ Deceased/Date of Death _____

COUNTRY OF BIRTH: ☐ US ☐ OTHER: _____

SOURCE OF REPORT

PHYSICIAN: _____

HOSPITAL/FACILITY: _____
(if applicable)

CITY: _____

PERSON COMPLETING FORM: _____

PHONE NUMBER: _____ DATE: _____

RISK FACTORS

PATIENT HISTORY SINCE 1977

Please check all that apply

Yes No Unk

Male/Male Sex ☐ ☐ ☐

Male/Female Sex ☐ ☐ ☐

IV Drug User ☐ ☐ ☐

Hemophilia- see back ☐ ☐ ☐

Heterosexual relations with
a person at known risk

VDU ☐ ☐ ☐

Bisexual male ☐ ☐ ☐

Hemophiliac - see back ☐ ☐ ☐

Transfusion recipient w/ HIV ☐ ☐ ☐

Person with HIV/AIDS ☐ ☐ ☐

Person from Pattern II entry ☐ ☐ ☐

Other possible risks of Pt.

Transfusion- see back ☐ ☐ ☐

Work in Health Care Field ☐ ☐ ☐

Specify: _____

HIV and AIDS case reporting is required by Montana Statute 37-2-301 and the Administrative Rules of Montana chapters 16.28.202 through 16.28.204.

For assistance with AIDS case reporting, call (406)-444-4744 or your local county health department.

TEST RESULTS

POS NEG UNK mm/dd/yy

ELISA ☐ ☐ ☐ _____

WESTERN BLOT/IFA ☐ ☐ ☐ _____

Other: _____ ☐ ☐ ☐ _____

CD4 COUNT and % _____ % _____

Has patient been dx with pulmonary TB? _____

AIDS CASE CRITERIA

Definite/Presumptive

mo/yr

CANDIDIASIS, Bronchia, Trachea or lungs ☐ ☐ _____

CANDIDIASIS, Esophageal ☐ ☐ _____

COCCIDIOIDOMYCOSIS, Disseminated ☐ ☐ _____

CRYPTOCOCCOSIS, extrapul. ☐ ☐ _____

CRYPTOSPORIDIOSIS/ Chronic Intestinal ☐ ☐ _____

CYTOMEGALOVIRUS, Other than liver/spleen/nodes ☐ ☐ _____

CYTOMEGALOVIRUS retinitis with vision loss ☐ ☐ _____

HIV ENCEPHALOPATHY ☐ ☐ _____

HERPES SIMPLEX: chronic ulcer(s) > 1 month duration ☐ ☐ _____

HISTOPLASMOSIS, disseminated or extrapulmonary ☐ ☐ _____

ISOSPORIASIS, chronic intestinal > 1 month duration ☐ ☐ _____

KAPOSI'S SARCOMA ☐ ☐ _____

LYMPHOMA, immunoblastic, Burkitt's or equivalent ☐ ☐ _____

LYMPHOMA, primary in brain ☐ ☐ _____

MYCOBACTERIUM AVIUM, M. Kansaii dissem. or extrapul. ☐ ☐ _____

MYCOBACTERIUM TUBERCULOSIS, extrapul. ☐ ☐ _____

MYCOBACTERIUM, other or unidentified species, extrapul. ☐ ☐ _____

PNEUMOCYSTIS Carinii pneu. ☐ ☐ _____

Progressive multifocal leukoencephalopathy ☐ ☐ _____

SALMONELLA septicemia ☐ ☐ _____

TOXOPLASMOSIS of brain ☐ ☐ _____

WASTING SYNDROME due to HIV (fever, diarrhea, loss of weight > 10% of baseline) ☐ ☐ _____

INSTRUCTIONS FOR COMPLETION OF AIDS CASE REPORT

Acquired Immunodeficiency Syndrome (AIDS) as defined by the Centers for Disease Control (CDC) is reportable by law in Montana.

Information to be reported is defined in chapter 16.28.204 of the Administrative Rules of Montana. Completion of this case report or a case report provided by CDC is required by the Montana Department of Health and Environmental Sciences. Completed case reports should be mailed to your local county health department or the Montana Department of Health and Environmental Sciences at the address listed on the front of the form.

All reports should be mailed in an envelope marked CONFIDENTIAL and ATTN: County Health Officer or Surveillance Coordinator. All reports received by the state will be confirmed by contacting the physician listed on the case report.

Instructions for Completing the AIDS ADULT CONFIDENTIAL CASE REPORT are provided below on items that may require clarification.

Soundex and Statno.- This information will be completed by the state.

County of Residence at Dx.- List the county, and state if not Montana, of patient's residence at the time of diagnosis of first AIDS indicator disease.

Heterosexual relations- Check all that apply, if a heterosexual partner was from a with a person at risk. a country where heterosexual transmission predominates (Pattern II) please specify country below.

Dx. of Pulmonary TB- If patient has been diagnosed with pulmonary Tuberculosis write yes; if patient has not write no; if unknown write unknown.

AIDS CASE CRITERIA- Check all that apply and provide approximate date of diagnosis of each indicator disease.

For classification under the surveillance definition of AIDS, most diseases must be diagnosed by definitive methods. Several indicator diseases may alternatively be diagnosed by other (presumptive) methods when the patient has a positive HIV test.

INDICATOR DISEASES AND MEANS OF DEFINITIVE DIAGNOSTIC METHODS

Candidiasis	Gross inspection by endoscopy or autopsy, or microscopy (histology or cytology) on a specimen obtained directly from the tissues affected (including scrapings from the mucosal surface), not from a culture
Coccidioidomycosis Cryptococcosis Herpes simplex virus Histoplasmosis	Microscopy (histology or cytology), culture, or detection of antigen in a specimen obtained directly from the tissues affected or a fluid from those tissues
Cryptosporidiosis Cytomegalovirus Isosporiasis Kaposi's sarcoma Lymphoma Pneumocystis pneumonia Progressive multifocal leukoencephalopathy Toxoplasmosis	Microscopy (histology or cytology)
Tuberculosis Other mycobacteriosis Salmonellosis	Culture
HIV encephalopathy* (dementia)	Clinical findings of disabling cognitive and/or motor dysfunction interfering with occupation or activities of daily living. In the absence of a concurrent illness or condition other than HIV infection that could explain the findings. Methods to rule out such concurrent illnesses and conditions must include cerebrospinal fluid examination and either brain imaging (computed tomography or magnetic resonance) or autopsy.
HIV wasting syndrome*	Findings of profound involuntary weight loss (more than 10% of baseline body weight) plus either chronic diarrhea (≥ 2 loose stools per day for ≥ 30 days) or chronic weakness and documented fever (for ≥ 30 days, intermittent or constant) in the absence of a concurrent illness or condition other than HIV infection that could explain the findings (e.g., cancer, tuberculosis, cryptosporidiosis, or other specific enteritis)

ADDITIONAL COMMENTS REGARDING THIS CASE:

ADDITIONAL RISK INFORMATION

Dates of transfusions: __/__/__ to __/__/__

Type of coagulation disorder:

Pattern II Country: _____

* For HIV encephalopathy and HIV wasting syndrome, the methods of diagnosis described here are not truly definitive but are sufficiently rigorous for surveillance purposes

APRIL 1991		Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			3													
Big Horn			4													
Blaine			5													
Broadwater																
Cerbon			1										1			
Carter																
Cascade			9		6			1					1			
Chouteau																
Custer			3											1		
Daniels																
Dawson																
Deer Lodge			1					1								
Fallon																
Fergus			2													
Flathead			9						1						1	
Gallatin			14				1							2		
Garfield																
Glacier			6				3					11				
Golden Valley																
Granite																
Hill			3		1			1								
Jefferson																
Judith Basin																
Lake			2		2											
Lewis & Clark			13	1			1	1				1		1		
Liberty																
Lincoln			3													
McCone																
Madison																
Meagher																
Mineral																
Missoula	3	15										1		1		
Musselshell																
Park			1													
Petroleum																
Phillips																
Pondera																
Powder River																
Powell			3													
Prairie			1													
Ravalli			1		1		1			1						
Richland																
Roosevelt			3		1										1	
Rosebud																
Sanders			1													
Sheridan																
Silver Bow			2													
Stillwater			1													
Sweet Grass														2		
Teton																
Toole																
Treasure																
Valley																
Wheatland																
Wibaux													1			
Yellowstone			31		3		1	2						1		
MONTHLY TOTAL	1991	3	137	1	14	0	7	6	1	1	0	13	3	8	2	0
	1990	9	128	8	23	1	3	1	0	0	0	7	6	2	10	1
	1989	4	134	4	52	0	1	5	1	0	0	6	27	7	5	0
TOTAL TO DATE	1991	17	449	28	38	3	48	28	3	4	4	22	7	42	4	3
	1990	16	272	27	34	1	20	15	1	2	1	12	12	10	12	7
	1989	11	504	17	81	2	15	16	1	0	1	22	26	21	58	5
OTHER DISEASES:		CHICKENPOX: Yellowstone - 24 Cascade - 7 Gallatin - 3 BAC. MENIN. UNSPEC.: Gallatin - 1														

MAY IS NATIONAL HIGH BLOOD
PRESSURE EDUCATION MONTH

The National High Blood Pressure Education Program Information Center has the following materials available for health care professionals, patients, and consumers;

- High Blood Pressure in Pregnancy
- Hypertension and Chronic Renal Failure
- Management of Patients with Hypertension and High Blood Cholesterol
- Ambulatory Blood Pressure Monitoring

To request these publications, contact;
Information Center
National Heart Lung and Blood Institute
4733 Bethesda Avenue, Suite 530
Bethesda, Maryland 20814-4820
Telephone (301) 951-3260

These materials are available year round.

IT LOOKS
LIKE A DUCK...

IT WALKS
LIKE A DUCK...

IT QUACKS
LIKE A DUCK....



BUT, UNTIL WE GET A POSITIVE TEST,
I CAN'T BE SURE!

- Reprinted from LYME DISEASE UPDATE

Volume: 15:4

Month of: April, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

1200 copies of this public document are published monthly at an estimated cost of 37¢ per copy, for a total cost of \$435.00, which includes \$300.00 for printing and \$135.00 for distribution.

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VOL. 15 NO.5

MAY, 1991

Montana State Department of Health and Environmental Sciences

MEASLES UPDATE

INDEX

Montana has been unscathed by the current measles epidemic in the neighboring states of Idaho and Utah. State health officials, to date this year, have not had a single confirmed case of measles in Montana. Nevertheless, residents are urged to be aware that the potential for transmission still exists.

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The state of Idaho has reported 265 confirmed measles cases and 100 suspect cases. The Idaho measles outbreak originated and continues in southern and central Idaho. Additional cases, however, have recently been reported in the panhandle region. Forty-four cases were recently reported in the Boise area. As of June 20, 1991, Utah reported 180 confirmed cases of measles. The Utah outbreak started and is still centered in the Davis County area north of Salt Lake City.

Travellers should be aware of the current measles outbreaks in Idaho and Utah, and be encouraged to be properly immunized against this disease.

Current recommendations for immunization include 2 doses of measles vaccine (MMR) for persons born after January 1, 1957. Persons born before this date are generally considered immune to measles, and do not require additional measles vaccination. Children may be vaccinated using MMR at 15 months of age. The American Academy of Pediatrics recommends a routine booster after 4 years of age. If the child is exposed to measles, or in an area where cases have occurred, the second dose is

recommended prior to the 4th birthday. The second dose may be administered as early as 1 month following the initial dose. Children under 15 months of age are discouraged from entering into areas where measles cases are being reported. Young children are at increased risk of developing measles-related complications.

Special attention should be paid to ensuring immunity among groups of children or young adults travelling to epidemic areas. Additionally, health officials should be aware of the potential for exposure by groups travelling into Montana for various gatherings. In certain situations, local officials have required documentation of immunity for out-of-state visitors participating in, or attending such gatherings. For more information, please contact your local health department, or the State Department of Health and Environmental Sciences at (406) 444-5580.

Any case of rash illness with fever should be promptly reported by telephone to the Montana Immunization Program at the above phone number.

MAY 1991	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis	
Beaverhead																
Big Horn																
Blaine																
Broadwater																
Carbon													1			
Carter																
Cascade								1			1		1			
Chouteau																
Custer																
Daniels																
Dawson																
Deer Lodge																
Fallon																
Fergus												1				
Flathead	1		1								1		1			
Gallatin											1					
Garfield																
Glacier			2													
Golden Valley																
Granite																
Hill														2		
Jefferson																
Judith Basin																
Lake			1													
Lewis & Clark			1			2										
Liberty																
Lincoln																
McCone																
Medison	2															
Meagher																
Mineral																
Missoula	3												1			
Musselshell																
Park										1						
Petroleum																
Phillips											2					
Pondera											1					
Powder River																
Powell																
Prairie																
Ravalli													4			
Richland																
Roosevelt	1					1								1		
Rosebud													1			
Sanders																
Sheridan												1				
Silver Bow													1			
Stillwater																
Sweet Grass																
Teton											1	2				
Toole																
Treasure																
Valley	1										2					
Wheatland	2															
Wibaux											1					
Yellowstone						2							1			
TOTAL MONTHLY TOTAL	1991	10	0	5	0	0	5	0	1	0	1	10	4	11	3	0
	1990	8	114	11	16	1	9	3	0	0	1	8	7	15	0	0
	1989	8	115	9	13	1	2	3	0	1	0	4	8	2	5	3
TOTAL TO DATE	1991	27	449	33	38	3	53	28	4	4	5	32	11	53	7	3
	1990	24	645	57	79	5	47	33	2	3	6	32	22	42	21	10
	1989	19	619	41	94	3	17	19	1	1	1	26	34	23	63	8

OTHER DISEASES: ORNITHOSIS: Fergus - 1

HEPATITIS C: Lewis & Clark - 2

COLORADO TICK FV: Missoula - 1

Park - 1

BAC MEN UNSPEC: Missoula - 1

CYTOMEGUIR ILL: Cascade - 1

Lewis & Clark - 1

Missoula - 1

KAWASAKI: Silver Bow - 1

CHICKEN POX: Cascade - 4

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
 Acquired Immunodeficiency Syndrome (AIDS)
 Definitive and Presumptive AIDS Cases
 Surveillance Report - As of May 31, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	37 (40)	26 (70)	1 (50)	1 (100)	38 (40)	27 (71)
Other Disease w/o PCP	54 (59)	32 (59)	1 (50)	0 (0)	55 (59)	32 (58)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
<u>No Diseases Listed</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>
Total	92 (100)	58 (63)	2 (100)	1 (50)	94 (100)	59 (63)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	79 (86)	0 (0)	79 (84)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	29 (31)	Hispanic	4 (4)	0 (0)	4 (3)
30-39	37 (39)	Native American	6 (7)	2 (100)	8 (9)
40-49	16 (17)	Unknown	<u>1 (1)</u>	<u>0 (0)</u>	<u>1 (1)</u>
Over 49	8 (9)	Total	92 (100)	2 (100)	94 (100)
<u>Unknown</u>	<u>0 (0)</u>				
Total	94 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	56 (67)	0 (0)	56 (61)
Intravenous (IV) Drug User	10 (12)	1 (13)	11 (12)
Homo/Bi IV Drug User	9 (11)	0 (0)	9 (10)
Hemophiliac	5 (6)	0 (0)	5 (5)
Heterosexual Contact	0 (0)	4 (50)	4 (4)
Transfusion With Blood/Products	0 (0)	2 (25)	2 (2)
<u>None of the Above/Other</u>	<u>4 (5)</u>	<u>1 (13)</u>	<u>5 (5)</u>
Total	84 (100)	8 (100)	92 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
<u>None of the above/Other</u>	<u>0 (0)</u>	<u>0 (0)</u>	<u>0 (0)</u>
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through May 31, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of May 31, 1991 there have been 296 cumulative positive HIV tests from 26,733 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of April 30, 1991, 174,893 cases of AIDS and 110,530 deaths have been reported to the Centers for Disease Control.

June-1991

¹Includes 71 Montana AIDS cases and 23 cases reported to Centers for Disease Control from other states who moved to Montana.

NEW FEE STRUCTURE FOR
PUBLIC HEALTH LABORATORY

Due to funding changes adopted during the last legislative session, the Department of Health and Environmental Sciences has proposed changes to the fees charged by the department's laboratories. The new fee structure in the Public Health Laboratory will be as follows.

1. The Newborn Screening fee will be \$9.00 per specimen.
2. Water Microbiology tests will be \$10.00 per test (total coliform, fecal coliform, plate count).
3. The handling fee for clinical specimens other than Newborn Screening will be \$5.00 per specimen.
4. The handling fee for environmental specimens other than for drinking water microbiology will be \$10.00 per specimen.
5. The license fee for laboratories performing analyses of public water supplies will be \$250.00.

These new fees are scheduled to take effect on July 12, 1991. Those with prepaid forms may continue to use the old forms after July 12, 1991. DHES will bill users for the fee difference. New forms will be available for purchase after July 1, 1991.

VIRAL HEPATITIS REPORTING

Local and county health workers are urged to use the updated Viral Hepatitis Case Report form (CDC 53.1, Rev. 8/89) when reporting cases of viral hepatitis. Please discard form CDC 53.1, Rev. 11/88. Current forms are available from DHES by calling 444-5580.

Workers are also urged to report cases of chronic hepatitis and chronic carriers. Please disregard the statement "Do not report cases of chronic hepatitis or chronic carriers." DHES is establishing a data base for hepatitis in Montana, and information is being sought on all subjects.

Volume: 15 No. 5

Month of: May, 1991

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Montana

Morbidity

Report



VOL. 15

NO. 6

June 1991

Montana State Department of Health and Environmental Sciences

HIV AND HEALTH CARE WORKERS: NEW GUIDELINES ANNOUNCED

U.S. Department of Health and Human Services Secretary Louis W. Sullivan, M.D., announced new guidelines on July 15, 1991, which state that any health care workers with HIV should not perform "exposure-prone" medical procedures in which blood contact might occur.

Emphasizing that there is no risk of transmitting HIV in the great majority of medical treatments, the guidelines are aimed at those procedures in which blood exposure could cause transmission, either to a patient from a health care worker or to a health care worker from a patient. The guidelines were drafted by the Centers for Disease Control in Atlanta.

The new guidelines say that dentists, physicians and other health care workers who perform exposure-prone procedures should find out their HIV and hepatitis B status. Any who are infected with HIV or the most virulent form of hepatitis B should not carry out such procedures unless they have obtained permission and guidance from special review committees which will require, at minimum, that potential patients be informed of the workers' HIV or hepatitis B status.

In addition, the guidelines emphasize the need for all physicians to follow carefully the "Universal Precautions" against infection, including such actions as thorough sterilization of equipment, careful handling and disposal of needles and other sharp instruments and the wearing of gloves when appropriate.

(See New HIV Guidelines, page 2)

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PERINATAL HEPATITIS B PREVENTION PROGRAM UNDERWAY IN MONTANA

The Montana Department of Health and Environmental Sciences has received federal funds to implement a statewide perinatal hepatitis B (HB) prevention program which targets infants born to HB surface antigen (HBsAg) positive women. The primary focus of the program is on screening pregnant women in Montana for HBsAg antibodies, and to ensure immunization and HBIG prophylaxis of the newborn (within 24 hours of birth). When referral of positive results of HBsAg screening are received, each case is followed-up by the PH Nurse Consultant to ensure the immunization and prophylaxis of the infant, identification of other persons at risk (i.e. household members, sex partners), education of persons at risk, and referral of high risk persons for immunization and/or chemoprophylaxis.

(See Hepatitis B Program, page 3)

New HIV Guidelines (Continued from page 1)

As used in the guidelines, "exposure-prone" procedures are those in which the worker might be cut or injured and his or her blood contact a patient's body cavity, subcutaneous tissues or mucous membranes. While the guidelines call for specialty groups to develop lists of these procedures, examples include abdominal, gynecological and heart surgery, and root canals and tooth extractions.

There was extensive public and professional input into the development of the new guidelines, CDC Director William Roper, M.D., said. "It is important that they be made widely available so that the American people can have the benefit of our best guidance on these issues."

Although the states, not the federal government, regulate the practice of medicine, the federal guidelines are expected to strongly influence professional standards and requirements. The guidelines:

- Seek enhanced teaching and scrupulous use of recommended "Universal Precautions" including sterilization of equipment and the careful handling and disposal of needles and other sharp instruments. Gloves should be worn by all health practitioners while performing invasive procedures and whenever they come in contact with blood or body fluids.

- Advise health care workers who perform exposure-prone invasive procedures to get tested for HIV (the AIDS virus) and for the hepatitis B virus. If infected with HIV or the most virulent form of hepatitis B, they should refrain from performing these procedures unless they have sought counsel from an expert review panel and have been advised under what circumstances, if any, they may continue to perform these procedures. Such circumstances would include notification of prospective patients before doing exposure-prone invasive procedures.

- Promote increased use of the hepatitis B vaccine for health care workers likely to be exposed to blood.

- Encourage research to identify modifications for medical, surgical and dental procedures and for equipment to reduce the risk of injuries to health care workers that might result in exposure of patients.

The guidelines were drafted by CDC after two days of public hearings in Atlanta and a 30-day public comment period. The recommendations were then reviewed by other components of the PHS. Further comments on the guidelines may be made to CDC.

James O. Mason, M.D., who, as HHS Assistant Secretary for Health heads the Public Health Service, said, "We must get across to the public that in most medical situations there's no more risk from a potentially HIV-infected nurse or doctor than from a lawyer, cab driver or teacher. AIDS will not be transmitted by most medical activities, from an electrocardiogram to the treatment of pneumonia to the radiation of a tumor. However, when surgery is performed, patients need to know that they will be protected by their dentists and physicians.

Transmission to patients has been shown only in one unusual cluster of five patients of a dentist in Florida.

CDC will distribute the new recommendations as a supplement to its Morbidity and Mortality Weekly Report. The recommendations will be distributed widely to physicians, dentists, nurses, professional schools and other interested parties. They may be obtained by calling the AIDS Hotline, 1-800-342-AIDS.

UPCOMING EVENTS

- | | |
|---------------|---|
| August 29-30 | <u>HIV Counselling Techniques Course</u> , Havre, MT.
Call Claudia at the AIDS Project; 444-3566 for more information. |
| October 23-24 | <u>HIV Counselling Techniques Course</u> , Missoula, MT.
Call Claudia at the AIDS Project; 444-3566 for more information. |
| October 24-27 | <u>Women and HIV - 1st WEstern Regional Conference</u>
Sponsored by the Western Regional AIDS Education Project. Phone 1-800-533-7669 for more info. |

Hepatitis B Program
(Continued from page 1)

Disease intervention activities are generally performed by local public health staff to offer counseling to the pregnant patient and follow-up for infants and other contacts (Household and sexual). In the event that local staff is unavailable or unable to follow up cases within program time frames and guidelines, the PH Nurse will provide assistance. Program funds are being used to provide vaccine and HBIG to newborns whose mothers are identified by the screening process.

To enlist the help of the private medical community, letters will be mailed to obstetricians, pediatricians, family practitioners, and other doctors likely to see pregnant HBsAg positive women or their babies. All physicians are asked to ensure that their pregnant patients receive HBsAg screening and that any positive results be reported to the Perinatal Hepatitis B Prevention Program at the Montana DHES.

The Department strongly recommends that the Montana Public Health Laboratory be used for all laboratory screening of pregnant women for HBsAg. Doctors who provide care for the contacts to HBsAg (+) pregnant women or provide care for the newborn infants should notify the Program of the status of those patients. Vaccine and HBIG is currently available, at no cost to the families, for immunization of the babies born to the HBsAg positive women.

The funding for this program is from the Centers for Disease Control and is expected to be long term.

If you have any questions about the program, comments, or a woman to refer, please call the Montana Immunization Program at 444-5580 and ask to speak with Joyce Burgett, RN.

To submit a specimen for Hep B screening, send the serum to the Montana Public Health Laboratory. Please indicate if this is a prenatal screen. The cost is \$5.00. For questions relating to collection of the serum or the laboratory test, please contact the Virology/Serology Section of the state lab at 444-2642.

* * * * *
* HIV/AIDS INFORMATION *
* * * * *

AIDS Planning Grant

The Montana Department of Health and Environmental Sciences has requested funding available through a federal grant to develop a comprehensive state plan addressing HIV/AIDS with the goal of:

- 1) Creating operational and long range planning processes with state agencies, local agencies, community based organizations, and existing programs;
- 2) Documenting a comprehensive response to the HIV/AIDS epidemic by the above agencies and organizations;
- 3) Assisting regional consortia, established under Title II of the Ryan White Act, to identify service needs and to target and coordinate resources;
- 4) Integrating the AIDS Drug Reimbursement and Home and Community Based Programs into the coordinated state plan of utilization of public and private resources.

Objectives to be addressed by the plan will be developed through the identification of Montana's needs and concerns during the development of a request for proposal. Two objectives that must be addressed by the plan are to:

- 1) Recommend what level of services are necessary to increase the awareness of and to prevent the further spread of HIV in the general population of Montana; and
- 2) Develop a statewide plan for a coordinated and effective system of health and human services delivery for those who are HIV infected, their families, and caregivers.

Other topics to be addressed by the plan are being added. Input from a wide range of individuals and organizations is being solicited. Watch your mail for a questionnaire or call 444-4744 for more information.

(See AIDS Planning Grant, page 4)

AIDS Planning Grant
(Continued from page 3)

This project represents Montana's first attempt at the development of a three to five year comprehensive long range plan with an emphasis on coordinating systems of care for those affected by HIV. It comes at a period when new services must be provided at the same time budget constraints are being realized. A comprehensive plan would enable us to study our options and best determine how to coordinate existing services, such as AIDS Drug Reimbursement and our Home and Community Based Services Grant, with new monies and services available under Titles II and III of the Ryan White C.A.R.E. Act.

The submitter of the proposal selected will enter into an agreement with MDHES and the Montana Area Health Education Center (AHEC) to develop such a plan using the guidelines outlined by MDHES, AHEC and other cooperating agencies, organizations or persons. If you are interested in receiving a copy of the request for proposal, please call 444-3565.

Chlamydia Screening

During March 1991, 365 Family Practice and OB/GYN physicians in Montana were surveyed for the use of chlamydia screening in their practice. Although the response to the survey was very good, the results indicated that many physicians do not selectively screen their patients for chlamydia infections.

Chlamydia trachomatis is the most prevalent sexually transmitted bacterial pathogen in the United State today. The importance of serious complications of chlamydial infections has been well established. Although laboratory tests for detection of Chlamydia trachomatis are widely available, diagnosis and treatment of these infections are still frequently based on clinical syndromes. Since most infected women are asymptomatic, these tests need much wider application.

Universal screening is preferable where rates of infection are high. When universal screening is not feasible, selective screening is recommended. Most authorities recommend screening all sexually active adolescents.

Diagnostic testing criteria should include:

1. Age younger than 25 years;
2. Pregnancy;
3. Post-coital breakthrough or other abnormal bleeding;
4. Vaginal smear with may polys without yeast or Trichomonas;
5. History indicating a new sexual partner, more than one sexual partner or partner with multiple sexual partners in women not using barrier contraception;
6. Signs and symptoms of chlamydia, including urethritis, cervicitis and pelvic inflammatory disease;
7. Signs and symptoms of other sexually transmitted diseases;
8. History of exposure to chlamydia, NGU, PID or epididymitis.

STD Interviewing Technique Course

The STD Program of MDHES will be offering a series of two day workshops throughout the state beginning this Fall. The intent of the workshops is to further develop interviewing skills for STD investigations. The STD Interviewing Technique courses will be presented at seven locations in order to limit long distance travel requirements. There will be no cost for the training session and stipends will be offered to those justifying the need. Application forms and course description will be outlined in a registration brochure to be mailed to all County Health Departments, Family Planning Clinics, IHS Clinics, STD Clinics, Student Health Services, and Job Corps Centers. If you are involved in interviewing STD clients and do not receive the application information by August 20, please call the STD Program at 444-3949.

The sites and dates for the courses are:

Helena	September	11 & 12
Billings	September	18 & 19
Havre	September	25 & 26
Kalispell	October	2 & 3
Sidney	October	9 & 10
Missoula	October	30 & 31
Great Falls	November	20 & 21

Measles Travel Advisory

Due to the continuing outbreaks of measles in states which are near Montana, and the potential for travelers to be exposed to measles when traveling outside of Montana, the Montana Department of Health recommends the following:

Anyone planning travel out of state should be immune to measles prior to leaving Montana. Persons born before 1957 are considered immune and generally do not need measles vaccination. All others should have documented evidence of having 2 doses of live measles vaccine, given at least 1 month apart. Both doses should have been given after the 1st birthday.

Children under 15 months of age should not go into areas where measles cases have been reported as children usually not protected against measles until they receive their 1st dose of measles vaccine at 15 months. Young children are at increased risk for developing measles related complications.

Anyone who is unsure of their immunization status should call their physician or their local health department.

Specific attention should be paid to ensuring measles immunity in groups of children who will be visiting an area where measles cases have been recently reported. (example: baseball, soccer, 4-H, church camps, boy scouts, rodeo, pow wows, etc.).

In certain situations, where potential measles exposure exists (baseball games, soccer tournaments), state and local officials are requiring persons to show written proof (Official Immunization Record) of measles immunity...for participants and fans.

NO MEASLES CASES HAVE BEEN REPORTED IN MONTANA TO DATE

Please report any rash illness with fever to the Montana Immunization Program immediately (444-5580).

Also, please notify your county health department if a group of children is planning to visit either Idaho or Utah this summer.

FDA WARNS ABOUT HIV TESTS

The Food and Drug Administration has stated that all saliva and urine tests which are being marketed are not FDA approved. The only HIV tests that are approved by the FDA are based on blood. The urine and saliva tests sold by Epitepe, Inc. and Home Office Reference Laboratory, Inc. are being used by insurance companies in Montana and around the U.S. The companies marketing the test believed they would not need to receive FDA approval if they sold the tests. The FDA has stated that all tests must undergo a set review for safety and efficiency before it can be marketed.

(Adapted from an article in the United Press International; 7/11/91 by Rob Stein)

CHANGES TO HIV INFORMED CONSENT

As of July 1, 1991, House Bill 917 replaced the AIDS Prevention Act of 1988, which impacts the written informed consent process for HIV antibody testing and counseling. Some of the changes apply to the performance of HIV testing by insurance companies and how a positive result is given to the patient. HB 917 also outlined the written informed consent procedures for HIV testing in the case of an "unconscious or otherwise mentally incapacitated" patient and in obtaining informed consent for occupational exposures.

For a copy of the new prototype informed consent form, please contact the AIDS Program at 444-3565. For copies of HB 917, please contact your local county commissioner's office.

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of June 30, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	41 (41)	29 (71)	1 (50)	1 (100)	42 (41)	30 (71)
Other Disease w/o PCP	58 (58)	34 (59)	1 (50)	0 (0)	59 (58)	34 (58)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	100 (100)	63 (63)	2 (100)	1 (50)	102 (100)	64 (63)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	86 (86)	0 (0)	86 (84)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	31 (30)	Hispanic	4 (4)	0 (0)	4 (3)
30-39	41 (40)	Native American	7 (7)	2 (100)	9 (9)
40-49	18 (18)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	8 (8)	Total	100 (100)	2 (100)	102 (100)
Unknown	0 (0)				
Total	102 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	61 (67)	0 (0)	61 (61)
Intravenous (IV) Drug User	11 (12)	1 (11)	12 (12)
Homo/Bi IV Drug User	9 (10)	0 (0)	9 (9)
Hemophiliac	5 (5)	0 (0)	5 (5)
Heterosexual Contact	0 (0)	5 (56)	5 (5)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (2)
None of the Above/Other	5 (5)	1 (11)	6 (6)
Total	91 (100)	9 (100)	100 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through June 30, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of June 30, 1991 there have been 302 cumulative positive HIV tests from 27,279 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of May 31, 1991, 179,136 cases of AIDS and 113,426 deaths have been reported to the Centers for Disease Control.

July-1991

¹Includes 76 Montana AIDS cases and 26 cases reported to Centers for Disease Control from other states who moved to Montana.

JUNE
1991

	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn	1	2													
Blaine		3						1							
Broadwater		1													
Carbon		2													
Carter								1							
Cascade		23		5							1	1	3	1	
Chouteau															
Custer		3													
Daniels															
Dawson								1							
Deer Lodge							2								
Fallon															
Fergus		2													
Flathead		7	2												
Gallatin		15							1				1		
Garfield															
Glacier		5				1									
Golden Valley															
Granite															
Hill		5		1				1							
Jefferson		1											1		
Judith Basin												1			
Lake		1	1								1				
Lewis & Clark		14	1			1	1				1				
Liberty															
Lincoln										1			1		
McCone															
Madison															
Meagher											1-				
Mineral															
Missoula	7	14	8			1	1						1		
Musselshell															
Park			1												
Petroleum															
Phillips															
Pondera												1			
Powder River															
Powell							1	1							
Prairie															1
Ravalli	1	1	2												
Richland		1													
Roosevelt		4													
Rosebud		1					1								2
Sanders					1										
Sheridan															
Silver Bow		3										1			
Stillwater										1	1				
Sweet Grass															
Teton											1				
Toole		1													
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone	2	39	2	2			2	1					1	1	
MONTHLY TOTAL	1991	11	149	17	8	1	3	8	6	1	2	5	4	1	1
	1990	22	117	14	20	1	14	5	0	1	2	2	4	8	3
	1989	10	74	12	12	1	10	6	1	0	0	9	1	9	0
TOTAL TO DATE	1991	38	598	50	46	4	56	36	10	5	7	37	15	61	6
	1990	46	762	71	99	6	61	38	2	4	8	34	26	51	10
	1989	29	693	53	106	4	27	25	2	1	1	35	45	29	8

OTHER DISEASES:

CHICKENPOX: Cascade-4
 PRIM. ENCEPH.: Gallatin-1
 TULAREMIA: Bighorn-2
 RMSF: Yellowstone-1

COLORADO TICK FEVER: Lewis & Clark-1
 Missoula-1
 Rosebud-1
 YERSINIOSIS: Yellowstone-1

E. COLI O157:
 Lewis & Clark-1
 Lincoln-1

CDC Voice Information System

The Centers for Disease Control has announced an automated telephone service that provides information about the CDC Morbidity and Mortality weekly Report (MMWR), and public health topics, including acquired immunodeficiency syndrome, chronic fatigue syndrome, Lyme disease, rabies, hepatitis, influenza, international travel, and malaria. Information includes an overview of each topic; symptoms; preventive measures; immunization requirements, if any; and an option for transfer to a public health professional during business hours. The CDC Voice Information System is available 24 hours a day, 365 days a year. The telephone number is (404) 332-4555.

NOTICE TO READERS

We are in the process of updating our mailing list. If you are receiving duplicate copies, or have a name or address change, please inform us. Also, if you know of anyone wishing to receive a copy of this publication or if you wish to discontinue receiving this publication, please contact us at: Department of Health and Environmental Sciences, Montana Morbidity Report, Communicable Disease Section, Cogswell Building, Room C-303, Helena, MT, 59620; or phone (406) 444-5580.

Volume: 15 No. 6

Month of: JUNE, 1991

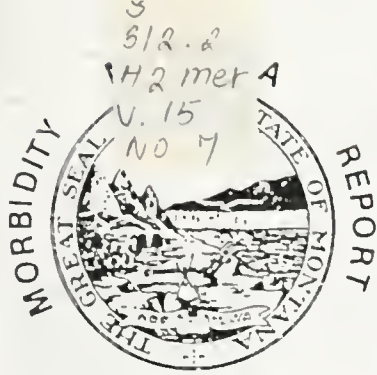
MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

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VOL. 15 NO. 7

July 1991

Montana State Department of Health and Environmental Sciences

FOODBORNE OUTBREAK, GALLATIN COUNTY AUGUST 1990

INDEX

On August 12, 1990, the Gallatin County Health Department was notified that gastro-intestinal disease symptoms had developed among the members of a birthday party following a meal at a local lodge the previous weekend. Initial investigation revealed additional cases among friends and relatives who dined at the lodge. A formal foodborne disease outbreak investigation was initiated.



During the evening of Friday, August 9, the implicated lodge had hosted a "Friday Night Hamburger Feed". 102 individuals were identified at risk. Phone contacts were established with 76 of these individuals. Of these, 68 reported being ill with gastro-intestinal disease symptoms including diarrhea, nausea, vomiting, fever, abdominal cramps and myalgia.

FOODBORNE OUTBREAK, GALLATIN COUNTY
BUG IN EPI-INFO SOFTWARE
OFFICIAL MONTANA IMMUNIZATION RECORD
MEASLES RECOMMENDATION
DESERT STORM DISEASES
VACCINE PURCHASES FOR PUBLIC PROVIDERS
CHOLERA EPIDEMIC
HIV RISK ASSESSMENT
RESIDENT AND NONRESIDENT AIDS
MONTANA MORBIDITY

Onset of illnesses began on 8/10, peaked on 8/11, and ended by 8/14. None of the ill subjects were hospitalized. The mean incubation period was 37 ± 11 (S.D.) hours. The mean duration of illness was 38 ± 21 hours. The case male:female ratio was 1:1.1. The median age of ill individuals was 34 years (range; 2-74), while the median age of non-ill individuals was 31 years (range; 7-48).

Food consumption histories were obtained on the 76 individuals. Calculated food-specific attack rates showed a statistically significant association between illness and consumption of potato salad (O.R.=51.33, $P < 0.0000$). Associations between illness & consumption of other foods were not significant. Stool specimens and food samples were collected.

Surveillance for additional cases of disease was heightened through press releases to local radio, television, and newspaper media. Also, a memo from the

(continued next page)

City-County Health Department was sent to Gallatin County physicians alerting them of the situation, and requesting their assistance in identifying additional cases.

Food at this gathering had been prepared and served by community volunteers. The potato salad consumed on 8/9 was prepared on 8/8 by several workers, one of which reportedly experienced an episode of a diarrheal illness prior preparing the potato salad. The eggs used to prepare the potato salad were store-bought....no reports of enteric illness were received from other sites in the community.

As compensation for their time and efforts, volunteers at the lodge on 8/9 were "rewarded" with leftover food. Potato salad was taken home by workers and served at a church and family picnic. Sixteen individuals at the church picnic and 7 attendees at the family picnic subsequently developed illness compatible with earlier cases. All ill subjects reported having eaten potato salad leftover from the "Friday Night Hamburger Feed". The disease incubation periods, durations, and food-specific attack rates were all consistent with findings associated with cases who dined at the lodge on 8/9.

Stool specimens were culture negative for suspected bacterial agents. Epidemiologists at CDC, Enterovirus Branch, were consulted. Suitable stool specimens were not available from cases for viral analysis, neither were acute phase blood specimens available for serologic analysis. CDC did not recommend forwarding food samples for analysis.

In summary and conclusion, during the period August 10-14, 1991, a total of 91 cases of gastrointestinal illness were identified in Gallatin Co. All cases except one were associated with the consumption of potato salad served at the lodge in Gallatin County on the evening of August 9. The overall case attack rate was 86%.

While the findings are inconclusive, they are consistent with a point-source outbreak of viral gastroenteritis. The nature, identity and source of the causative agent is not known. The possible role of a

chemical intoxication has not been excluded.

Additional cases have not been identified to date. Further cases are not expected. Proper food handling and personal hygiene would have likely prevented this outbreak.

BUG IN EPI-INFO SOFTWARE

If you write programs in ANALYSIS of Epi-Info, version 5.01a, you should know that a bug in the DIV operator has been reported which in some cases returns the wrong result when DIV is used to obtain the fractional part of a real number. The same bug affects the use of RECODE using the BY command, as in RECODE AGE TO AGEGROUP BY 5, sometimes recoding ages, for example, into incorrect groups. Other RECODES, those without BY, are not affected.

Although many users do not invoke these functions, the software producers want users to be aware of the difficulty, since it can potentially give incorrect results. If you use these functions, and would like a new disk, send a note requesting a corrected disk to the following address, and they will be glad to send you one.

USD, Incorporated
2075-A West Park Place
Stone Mountain, GA 30087
Phone (404) 469-4098

OFFICIAL MONTANA IMMUNIZATION RECORD AVAILABLE

The official Montana Immunization Record (trifold wallet card) is now available free of charge from the Montana Department of Health and Environmental Sciences' Immunization Program. This is a personal record printed by Blue Cross and Blue Shield to be kept by the client or the parent. The program recommends that everyone, including adults, obtain one of these cards. The OMIR may be obtained by calling 444-5580.

DESERT STORM DISEASES

MEASLES RECOMMENDATION

Correction and Comment

The May 1991 Montana Morbidity Report, (Measles Update, page 1) incorrectly reported that "The American Academy of Pediatrics (AAP) recommends a routine booster after 4 years of age." The AAP recommends the 2nd dose be given by 12 years of age. Complete AAP measles recommendations are contained in the 1991 RED BOOK.

The Immunization Practices Advisory Committee (ACIP), however, does have a recommendation for the 2nd dose to be given routinely when children enter kindergarten or first grade (4 - 6 years of age).

The issue on when the 2nd dose of MMR should be routinely given has created some confusion. One must realize that dates and ages set forth by different advisory groups are rather arbitrary. Current guidelines are not uniform or rigid. The important issue is to ensure that subjects at greatest risk of acquiring measles have received 2 doses of vaccine.

The two-dose vaccine schedule is expected to provide protection to persons who did not fully respond to their initial vaccination. The first dose is recommended at 15 months of age, but can be administered as early as 12 months of age for children in high risk situations. The second dose may be administered as early as a month later. This accelerated schedule, however, is generally used only when measles exposure is likely (eg., epidemic situations, or travel to such areas). The Administrative Rules of Montana related to school and day care measles vaccine requirements are being written to require the 2nd dose of measles vaccine to be given prior to entering middle school or junior high and post-secondary school. Due to funding limitations, DHES has targeted high risk junior high and middle school entrants as candidates for vaccination.

If you have any questions or comments, please contact Richard Paulsen, Immunization Program Manager, at 444-5580.

While Montana has not received reports of significant medical problems among persons returning from the Persian Gulf, several endemic diseases of the area may be unfamiliar to Montana health care providers.

The most common diseases encountered in the Middle East were enteric infections such as amebiasis, giardiasis, hepatitis A, salmonellosis, and shigellosis. Endemic vectorborne diseases include malaria, leishmaniasis, Crimean-Congo hemorrhagic fever, and typhus. Other endemic diseases include schistosomiasis, rabies, and brucellosis. These diseases should be considered in the differential diagnosis of otherwise unexplained illnesses of persons who have returned from the Middle East.

VACCINE PURCHASES FOR PUBLIC PROVIDERS

For health care providers who use federal, state, or local funds, there may be the ability to purchase some additional vaccines at special contract prices on either state or federal contracts. These purchases are coordinated out of the State Immunization Program Office and require some participation on our part. The requirements that apply for the vaccine that the state provides, for example, duty to warn, also apply here. There also may be no ability to return the vaccine. The following table provides some general information. Please contact us for further details.

<u>VACCINE</u>	<u>MIN ORDER</u>	<u>VACCINE</u>	<u>MIN ORDER</u>
MMR*	500 - 1000	PED DT	\$ 500
OPV	100	AD TD	1,000
HIB LP	50	HEPBV	36 or 360**
HIB MSD	50	HEPBIG	10 or 50**
INFLUENZA	1000	IPV	10
PNEMOCOCCAL	50	RABIES***	150

* MR AND SINGLE ANTIGEN VACCINES ALSO AVAILABLE.

** THE MINIMUM ORDER DEPENDS ON SIZE OF VIAL ORDERED.

*** THIS INCLUDES RABIES PRE & POST EXPOSURE VACCINE & IMMUNE GLOBULIN

CHOLERA EPIDEMIC, SOUTH AMERICA
Travelers Advisory



Travelers to Peru, Ecuador and Colombia should be aware that an epidemic of cholera is affecting those countries. A small number of cholera cases has been reported in Chile and in Brazil, near the border with Peru.

Several cases of cholera in U.S. travelers to South America have been reported, and cholera cases in the U.S. were caused by

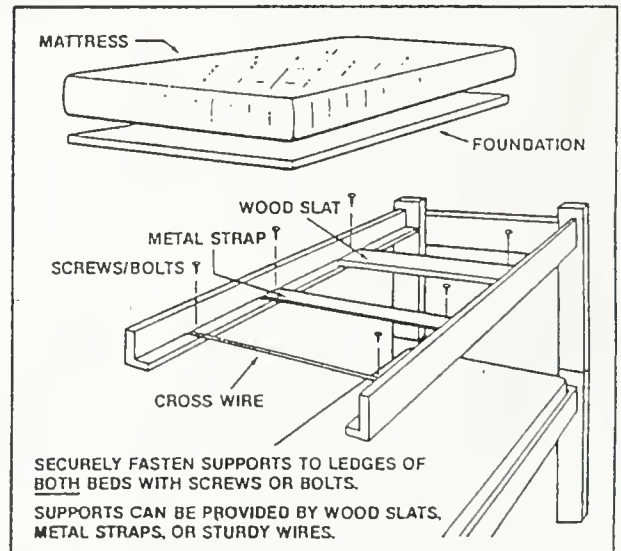
seafood brought back from South America in travelers' baggage. Since cholera is associated with poor sanitation, the risk of cholera to travelers following normal tourist itineraries has been exceedingly low in other cholera epidemics. The usual precautions to avoid travelers diarrhea should be observed closely. It is particularly important to avoid raw or undercooked seafood, to avoid food and beverages from street vendors, to avoid uncooked vegetables and fruits (unless peeled by traveler, to avoid ice in beverages, and to drink only boiled water or bottled carbonated beverages. Travelers should not bring back seafood in their baggage. Travelers developing severe watery diarrhea during or in the week following travel through epidemic areas should seek medical attention immediately.

The vaccine for cholera confers only brief and incomplete protection and is not recommended. There are no cholera vaccine requirements for entry or exit into South American countries or the United States.

For more information about cholera, call the international travelers' hotline and listen to the outbreak menu at (404) 332-4559, available 24 hours a day, 7 days a week.

SAFETY ALERT

The Consumer Product Safety Commission is aware of four deaths to children since 1980 which occurred when the mattress and foundation of the bunk beds became dislodged and fell on them. In three of these incidents, the children were playing on the floor under the bed. Falling mattresses or foundations can cause injury or kill a small child. Mattresses and/or foundations resting only on ledges need cross wires, or other means of support to help prevent dislodgement, even when beds are not stacked. Consumers can write to: Bunk Bed Kit, P.O. Box 2436, High Point, NC 27261, and ask for a free cross-wire support kit.



JULY 1990		Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			4													
Big Horn			5													
Blaine	1	3														1
Broadwater																
Carbon	2				1											
Carter																
Cascade	3	23	1	6								1				1
Chouteau																
Custer		1						1								
Daniels																
Dawson	1	2														
Deer Lodge		2						1								
Fallon		1														
Fergus		1														
Flathead	3	11	6									11	1	2		
Gallatin	1	23							1							
Garfield																
Glacier		11					2		1							
Golden Valley																
Granite																
Hill		5		1												
Jefferson		1														
Judith Basin																
Lake		5														
Lewis & Clark	1	20	4					1				1				
Liberty																
Lincoln		4	1									1		2		
McCone																
Madison																
Meagher																
Mineral																
Missoula		21	3	3			1	2			2	1		2		
Musselshell																
Park		2												1		
Petroleum																
Phillips													1			
Pondera																
Powder River																
Powell		3	1													
Prairie																
Ravalli	1	10												6		
Richland		1												1		
Roosevelt		8														
Rosebud																
Sanders		1														
Sheridan																
Silver Bow		10		1												1
Stillwater		2														
Sweet Grass																
Teton																
Toole													1			
Treasure																
Valley																
Wheatland																
Wibaux																
Yellowstone		47		2			1	2					1		3	
MONTHLY TOTAL	19 91	13	227	16	14	0	4	5	4	0	2	15	4	15	3	3
	19 90	14	135	20	24	2	6	5	2	0	2	13	6	13	4	0
	19 89	17	110	18	14	1	7	8	1	1	0	15	10	17	3	4
TOTAL TO DATE	19 91	51	826	66	60	4	60	41	14	5	9	52	19	76	12	6
	19 90	60	897	91	123	8	67	43	4	4	10	47	32	64	26	10
	19 89	46	803	71	120	5	34	33	3	2	1	50	55	36	69	12
OTHER DISEASES:		COLORADO TICK FEVER:										CMV: Cascade - 1				
CHICKENPOX: Cascade - 1		Bighorn - 1										Lewis & Clark - 1				
PERTUSSIS: Roosevelt - 1		Flathead - 1										RMSF: Carter - 1				
TULAREMIA: Bighorn - 1		Madison - 1										Fallon - 1				
E. COLI O157: Cascade - 1		LEGIONELLOSIS:														
YERSINIOSIS: Lewis & Clark - 1		Yellowstone - 1														

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of July 31, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	42 (42)	30 (71)	1 (50)	1 (100)	43 (42)	31 (72)
Other Disease w/o PCP	58 (57)	36 (62)	1 (50)	0 (0)	59 (57)	36 (61)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	101 (100)	66 (65)	2 (100)	1 (50)	103 (100)	67 (65)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	87 (86)	0 (0)	87 (84)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	31 (30)	Hispanic	4 (4)	0 (0)	4 (4)
30-39	42 (41)	Native American	7 (7)	2 (100)	9 (9)
40-49	18 (17)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	8 (8)	Total	101 (100)	2 (100)	103 (100)
Unknown	0 (0)				
Total	103 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	62 (67)	0 (0)	62 (61)
Intravenous (IV) Drug User	11 (12)	1 (11)	12 (12)
Homo/Bi IV Drug User	9 (10)	0 (0)	9 (9)
Hemophiliac	5 (5)	0 (0)	5 (5)
Heterosexual Contact	0 (0)	5 (56)	5 (5)
Transfusion With Blood/Products	0 (0)	2 (22)	2 (2)
None of the Above/Other	5 (5)	1 (11)	6 (6)
Total	92 (100)	9 (100)	101 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MOHES, through July 31, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of June 30, 1991 there have been 305 cumulative positive HIV tests from 27,865 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of June 30, 1991, 182,834 cases of AIDS and 115,984 deaths have been reported to the Centers for Disease Control.

July-1991

¹ Includes 78 Montana AIDS cases and 25 cases reported to Centers for Disease Control from other states who moved to Montana. A case originally listed as an out-of-state case was reclassified as a Montana case during July.

HIV RISK ASSESSMENT

Assessing a client for risk of HIV/AIDS is not always easy. Our health care setting is already burdened with assessing clients on many diverse health problems and issues. Assessing for risk of HIV, however, is not as difficult as it seems. Most health care workers are already asking the basic HIV assessment questions in the process of investigating other diseases and health problems. It just takes thinking about the possibility of HIV/AIDS while asking those questions.

Firstly, what are the risks and how do you ask about them? The risks are straightforward; any activity or history that would allow the passage of blood, semen, vaginal fluids is a risk for HIV, except in monogamous relationships where both partners are determined to be HIV negative. Below are helpful examples of HIV risk assessment questions. They are broken-up into three parts depending on the focus of your facilities; however, the other areas also need to be included for a total HIV risk assessment.

Sexual History

1. Have you had 5 or more sex (oral, anal or vaginal) partners in any year since 1979?
2. With whom do you have sex?
Men Women Both
If applicable; what is your current choice of birth control?
3. How often do you use a condom while having sex (oral, anal, or vaginal)?
Never Sometimes Always
Almost always
Only with: anal vaginal oral all
4. When was the last time you or your partner were treated for a sexually transmitted disease?
5. For Women: When was the last time you had sex with a bisexual male?
6. When have you ever had sexual intercourse (anal, vaginal or oral) with someone who is HIV positive?
7. When was the last time you or your partner had sex (anal, oral or vaginal) with someone outside of your relationship(Male or Female)?

8. When was the last time you or your partner traded sex for drugs/money?
9. When was the last time you or your partner had sex with someone who performs sex acts for money/drugs?
10. Have you ever been victimized sexually?

Drug History

1. When was the last time you used injectable drugs (including steroids)?
If applicable; When was the last time you shared needles?
2. When was the last time your partner used injectable drugs?
3. When was the last time you had sex under the influence of drugs or alcohol?

Other Areas

1. Are you or your partner a hemophiliac?
2. When was the last time you or your partner had a blood transfusion or tissue transplant?
3. Have you ever worked/volunteered in a health care setting or setting where there was blood exposure?
 - a. If yes: when was the last time you had a needlestick or blood exposure in this setting?
 - b. When was the last time you were tested for HIV antibodies?
5. Were you born or lived in a country where there is no screening of blood or tissue for HIV?

An HIV risk-assessment survey is soon to be distributed to Family Planning/STD clinics, Family Practice, OB/GYNs, Perinatal and Chemical Dependency Programs. If you receive a survey please respond. It is a survey to help your faculty in HIV risk-assessment. If you have any comments or questions about the survey or about HIV risk-assessment please call Amy E. Harris at the AIDS Program, 444-2675.

AVAILABILITY OF H.U.D FUNDS FOR
PERSONS WITH AIDS

The Department of Housing and Urban Development (HUD) announced a notice of funds availability for Fiscal Year 1991 in the Federal Register on June 12, 1991. Specific funding in the amount of \$32,679,000 has been set aside to construct, renovate or purchase housing for persons with AIDS. The HUD funds set aside provide for 500 units across the country in respective HUD regions. In addition, approximately \$32,000,000 will be available for tenants in these facilities to be used as rental assistance.

The organizational deadline for the filing of the applications has been extended to September 30, 1991. Specific points of interest for this program are:

- The availability of capital advances to construct, renovate, or purchase housing facilities.
- An organization eligible to participate as a sponsor or owner must be a private, not-for-profit corporation. City, State or municipal corporations or their affiliate organizations are not eligible for participation.
- The corporation participating as owner must be a single asset corporation, and among other things the application must show that there is specific demand and need for this type of housing.

Interested applicants should contact their local HUD field offices for application kits and additional, or Jim Murphy/Bruce Desonia at the DHES AIDS/STD Program, phone: (406) 444-2457.

Volume: 15 No. 7

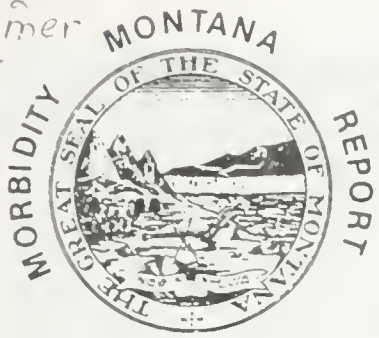
Month of: July, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

1200 copies of this public document are published monthly at an estimated cost of 37¢ per copy, for a total cost of \$435.00, which includes \$300.00 for printing and \$135.00 for distribution.

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INFLUENZA RECOMMENDATIONS, 1991-92

These recommendations update information on the vaccine and antiviral agents available for controlling influenza during the 1991-1992 influenza season. The primary changes include statements about the influenza strains in the trivalent vaccine for 1991-1992.



INTRODUCTION

Typical influenza is characterized by abrupt onset of fever, muscle ache, sore throat, nonproductive cough and severe malaise lasting several days. More severe illness can result if primary influenza pneumonia or secondary bacterial pneumonia occur. Elderly persons and persons with underlying health problems are at increased risk for complications of influenza infection. Increased mortality results not only from influenza and pneumonia, but also from cardiopulmonary and other chronic diseases that can be exacerbated by influenza infection. Due to increases in the proportion

(Continued on Page 2)

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SUBSTANCE ABUSE AND HIV

U.S. VACCINATION EFFORTS
NEED A SHOT IN THE ARM

A federal government advisory committee on immunizations revealed that the U.S. record in vaccinating children age 2 and under is probably worse than that of any country in the Western Hemisphere except Bolivia and Haiti. According to the committee chair, D.A. Henderson, the measles immunization rate for 2-year-olds in the U.S. is lower than the rates reported by 28 out of 38 countries in Latin America and the Caribbean. Says Henderson; "This isn't a measles problem. It's a systems problem. We need to think about how we can better provide care so that children are assured of getting the vaccine. Neither money nor parental incentives will be enough to solve the problem. We must also remove administrative barriers such as insisting that children have physical examinations before they are immunized, or refusing to vaccinate children who have colds."

of our elderly, and to increases in the number of younger persons at increased risk for influenza-related complications, the toll from this disease can be expected to increase unless control measures are used more vigorously.



OPTIONS FOR CONTROL

Two measures are available in the U.S. that can reduce the impact of influenza; 1) vaccination, and 2) chemoprophylaxis or therapy with an influenza-specific antiviral drug (eg., amantadine). Vaccination of high-risk persons each year before the influenza season is currently the most effective measure.

INACTIVATED INFLUENZA VACCINE

Influenza vaccines consist of inactivated virus particles. Therefore, the vaccine cannot cause influenza. Each year's vaccine contains 3 virus strains (usually 2 type A and one type B) likely to circulate in the U.S. in the upcoming winter. The trivalent influenza vaccine prepared for the 1991-92 season will include A/Taiwan/1/86-like(H1N1), A/Beijing/353/89-like(H3N2) and B/Panama/45/90.

RECOMMENDED VACCINE USE

Influenza vaccine is strongly recommended for any person >6 months of age who, because of age or underlying medical conditions, is at increased risk for complications of influenza. Health care workers and others (including household members) in

close contact with high risk persons should also be vaccinated. Vaccine may also be given to any person who wishes to reduce the chance of infection. Annual vaccination using the current vaccine is necessary because immunity for an individual declines in the year following vaccination. Also, because the current vaccine differs antigenically from previous vaccines, supplies of 1990-91 vaccine should not be used to provide protection for this season. Adults and older children should be vaccinated in the deltoid muscle, and infants and young children in the anterolateral aspect of the thigh. Recommended doses are listed in Table 1.

TARGET GROUPS FOR VACCINATION

A. Groups at Increased Risk for Complications.

1. Persons ≥ 65 years of age.
2. Residents of nursing homes and other chronic-care facilities.
3. Persons with chronic disorders of the pulmonary or cardiovascular systems, including children with asthma.
4. Persons with chronic metabolic diseases.
5. Children and teens (age 6 months-18 yrs) who are receiving long-term aspirin therapy.

B. Groups in Contact With High-Risk Persons.

1. Physicians, nurses, and other personnel in hospitals and outpatient-care settings who have contact with high-risk persons among all age groups, including infants.
2. Employees of nursing homes and chronic-care facilities who have contact with patients or residents.
3. Providers of homecare to high-risk persons.
4. Household members (including children) of high-risk persons.

C. Other Groups

1. Any person who wishes to reduce the chance of acquiring influenza infection.
2. Persons who provide essential community services (firemen, police

officers, etc.,) in order to minimize disruption of essential activities during epidemics.

3. HIV-infected persons, because influenza may result in a more serious illness.
4. Pregnant women with medical conditions that increase their risk of complications (the vaccine is considered safe for pregnant women).

PERSONS WHO SHOULD NOT BE VACCINATED

Inactivated influenza vaccine should not be given to persons known to have anaphylactic hypersensitivity to eggs. Persons with acute febrile illnesses usually should not be vaccinated until their symptoms have abated.

SIDE EFFECTS AND ADVERSE REACTIONS

Because influenza vaccine is noninfectious, it cannot cause influenza. Respiratory disease after vaccination represents coincidental illness unrelated to vaccination. The most frequent side effect of vaccination is soreness at the vaccination site that may last for up to 2 days; this is reported for fewer than one-third of vaccinations. Unlike the 1976 swine influenza vaccine, subsequent vaccines prepared from other virus strains have not been clearly associated with an increased frequency of Guillain-Barre' syndrome. Although influenza vaccination can inhibit the clearance of warfarin and theophylline, studies have failed to show any adverse clinical effects attributable to these drugs among patients receiving influenza vaccine.

SIMULTANEOUS ADMINISTRATION OF OTHER VACCINES

The target groups for influenza and pneumococcal vaccination overlap considerably. Both vaccines can be given at the same time at different sites without increasing side effects. However, influenza vaccine must be given each year; with few exceptions, pneumococcal vaccine should be given only once.

USE OF AMANTADINE

Chemoprophylaxis is not a substitute for vaccination. Recommendations for chemopro-

phylaxis are provided primarily to help healthcare providers make decisions regarding persons who are at greatest risk of severe illness and complications if infected with an influenza A virus. The antiviral agent available for use at this time (amantadine hydrochloride) is effective only against influenza A and, for maximum effectiveness as prophylaxis, must be used throughout the period of risk. When used as either prophylaxis or therapy, the potential effectiveness of amantadine must be balanced against potential side effects. Use of amantadine may be considered:

1. As a control measure when influenza A outbreaks occur in institutions housing high-risk persons, both for treatment of ill individuals and as prophylaxis for others;
2. As short-term prophylaxis after late vaccination of high-risk persons during the period when immunity is developing in response to vaccination;
3. As seasonal prophylaxis for individuals for whom vaccination is contraindicated; and
4. As seasonal prophylaxis for immunocompromised individuals who may not produce protective levels of antibody in response to vaccination

TIMING OF INFLUENZA VACCINATION ACTIVITIES

Beginning each September, when vaccine for the upcoming influenza season becomes available, high-risk persons who are hospitalized or who are seen by healthcare providers for routine care should be offered influenza vaccine. Except in years of pandemic influenza (eg., 1957 and 1968), high levels of influenza activity rarely occur in the contiguous 48 states before December. Therefore, November is the optimal time for organized vaccination campaigns for high-risk persons. In facilities such as nursing homes, it is particularly important to avoid administering vaccine too far in advance of the influenza season because antibody levels begin declining within a few months. Vaccination programs may be undertaken as soon as the current vaccine is available if regional influenza activity is expected to begin earlier than December. Children <9

years of age who have not previously been vaccinated should receive two doses of vaccine at least a month apart to maximize the chance of satisfactory antibody response to all 3 vaccine antigens. The second dose would be given before December, if possible. Vaccine should be offered to

both children and adults up to and even after influenza virus activity is documented in a community, as late as April in some years.

*Condensed from: CDC. MMWR 1991; 40(RR-6):1-15. Consult reference for full text.

TABLE 1. Influenza vaccine* dosage, by patient age — United States, 1991–92 season

Age group	Product [†]	Dosage	No. doses	Route [‡]
6-35 mos.	Split virus only	0.25 mL	1 or 2 [¶]	IM
3-8 yrs.	Split virus only	0.50 mL	1 or 2 [¶]	IM
9-12 yrs.	Split virus only	0.50 mL	1	IM
≥12 yrs.	Whole or split virus	0.50 mL	1	IM

*Contains 15µg each of A/Taiwan/1/86-like (H1N1), A/Beijing/353/89 (H3N2), and B/Panama/45/90-like hemagglutinin antigens in each 0.5 mL. Manufacturers include: Connaught Laboratories, Inc. (distributed by E.R. Squibb & Sons, Inc.) (Fluzone[®] whole or split); Evans Medical Ltd.-Lederle Laboratories (distributed by Lederle Laboratories) (Flu-Imune[®] purified surface antigen vaccine); Parke-Davis (Fluogen[®] split); and Wyeth-Ayerst Laboratories (Influenza Virus Vaccine, Trivalent[®] split). For further product information call Connaught, (800) 822-2463; Lederle, (800) 522-3753; Parke-Davis, (800) 233-0432; Wyeth-Ayerst, (800) 950-5099.

[†]Because of the lower potential for causing febrile reactions, only split-virus vaccines should be used for children. They may be labeled as "split," "subvirion," or "purified-surface-antigen" vaccine. Immunogenicity and side effects of split- and whole-virus vaccines are similar for adults when vaccines are used at the recommended dosage.

[‡]The recommended site of vaccination is the deltoid muscle for adults and older children. The preferred site for infants and young children is the anterolateral aspect of the thigh.

[¶]Two doses are recommended for children <9 years of age who are receiving influenza vaccine for the first time.

HEAD LICE ALERT

There has been a recent resurgence in head lice infestations in Montana. Dr. Kenneth Quickenden, an entomologist with Department of Health and Environmental Sciences has noted that the number of positive hair specimens received this year is significantly greater than previous years. With the beginning of the school year, health care workers are urged to be on increased alert to the appearance of lice.

Head lice are an age old problem. While poor living conditions, overcrowding and lack of personal cleanliness can contribute to louse population growth, infestation is not a reflection on an individuals or families hygienic practices. Lice can spread even when the level of cleanliness is high. Head lice in schools, institutions, and other facilities can only be controlled, not eliminated. Sporadic occurrence and recurrence of lice takes

place even after control efforts have been instituted. The goal is to detect infestations early, reduce the problem and minimize spread.

Transmission most often occurs following either close contact with infected individuals or their personal articles such as combs, hairbrushes, hats and similar items. Head lice are spread only from person to person, not from or to dogs, cats, or other pets. Head lice do not jump or fly, they crawl. They require a warm environment and blood meals about every 4 hours to survive. Carpets and furniture are not a favorable place for lice....they will die at room temperature in 12-48 hours if away from the warmth, moisture and blood of a host. Still, heavily used overstuffed furniture and bedding may be a factor in spreading lice and control in the home environment will also be required.

Diagnosis is made by inspection of a person's hair. Adult lice are 1-2 mm long and are tan to grayish-white in color. They lay eggs or "nits" on hair shafts near the scalp. Adult lice, nymphs and/or nits can usually be seen with the naked eye or with a hand lens or microscope. Nits can be differentiated from dandruff and hair casts because they are firmly adherent to the hair shaft, and cannot be easily picked, combed, or rubbed off. Be aware that "pseudo-outbreaks" of lice have occurred in Montana due to misdiagnosis. Head lice can live for up to 30 days, and females can lay about 4 eggs daily. The eggs hatch in 8 to 10 days and the nymphs may become egg-laying adults 10 days later.

When lice infestation is found, treatment should begin as soon as possible. There are various pediculicidal shampoos and cream rinses available. All directions on the pediculicide label must be followed. Over the counter pyrethrin-based products (such as RID, Pyrinate A-200, R&C shampoo, Barc, Para-trol, Para-nit and Triple-X) are recommended. Permethrins (such as Elimite cream and Nix), are equally acceptable options. Lindane solutions (such as KWELL and generic equivalents) are not often recommended as the treatment of choice because: 1) treatment failures have been reported; and 2) other products have lower potential toxicity than lindane. Studies have shown that some shampoos may be only 70% effective at killing the nits and that re-infestation is fairly common during the early stages of pediculosis control programs. Therefore, unless all nits are removed (which can be difficult), re-treatment is recommended on the 10th or 11th day following the initial treatment. Treatment should be accompanied by efforts to physically remove as many nits as possible. Specially designed nit combs available at pharmacies are helpful in nit removal.

Control of head lice has traditionally been an issue for school officials. Enforcement is the responsibility of the school. School nurses or other personnel trained in detecting infestation of head lice, should assess whether a child is infested. If active infestation is detected, the family should be notified, and the child should be kept out of school until properly treated.

Some schools require removal of all nits before children may return (No Nit Policy). Such a policy is encouraged....approval of the local board of education is generally required. Once a child has been found to have head lice, all classmates and siblings should be observed for symptoms (eg., excessive scratching of one's head) or for the presence of nits. Local health department involvement in the control of head lice in schools varies. Most health departments are willing to train school personnel in detecting head lice infestation, or to screen children who have had head lice and need to return to school.

For further information or answers to questions regarding the control of lice, please call the DHES, Vector Control Section at (406) 444-5303. Limited numbers of Head Lice Control pamphlets are available.



HIV COUNSELING COURSE

The Montana Department of Health and Environmental Sciences, AIDS/STD Program is sponsoring an HIV Counseling Techniques Course at St. Patrick's Hospital auditorium on October 23-24. This will be the last course offering for calendar year 1991. For more information and registration material, contact Claudia Montagne at the AIDS/STD Program; (406) 444-3566.

MONTANA
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Acquired Immunodeficiency Syndrome (AIDS)
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1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	44 (42)	31 (70)	1 (50)	1 (100)	45 (42)	32 (71)
Other Disease w/o PCP	60 (57)	36 (60)	1 (50)	0 (0)	61 (57)	36 (59)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	105 (100)	67 (64)	2 (100)	1 (50)	107 (100)	68 (64)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	91 (87)	0 (0)	91 (85)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	31 (29)	Hispanic	4 (4)	0 (0)	4 (4)
30-39	44 (41)	Native American	7 (7)	2 (100)	9 (8)
40-49	20 (19)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	8 (7)	Total	105 (100)	2 (100)	107 (100)
Unknown	0 (0)				
Total	107 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	64 (67)	0 (0)	64 (61)
Intravenous (IV) Drug User	11 (12)	1 (10)	12 (11)
Homo/Bi IV Drug User	10 (11)	0 (0)	10 (10)
Hemophiliac	5 (5)	0 (0)	5 (5)
Heterosexual Contact	0 (0)	6 (60)	6 (6)
Transfusion With Blood/Products	0 (0)	2 (20)	2 (2)
None of the Above/Other	5 (5)	1 (10)	6 (6)
Total	95 (100)	10 (100)	105 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through August 31, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of August 31, 1991 there have been 305 cumulative positive HIV tests from 28,498 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of July 31, 1991, 186,895 cases of AIDS and 118,411 deaths have been reported to the Centers for Disease Control.

July-1991

¹Includes 80 Montana AIDS cases and 27 cases reported to Centers for Disease Control from other states who moved to Montana.

AUGUST 1991		Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			4									1				2
Big Horn			12													
Blaine			1													
Broadwater																
Carbon			4	1												
Carter																
Cascade	1	7	3					1				3	2			1
Chouteau																
Custer			1													
Daniels																
Dawson			2													
Deer Lodge			1													
Fellon																
Fergus			2										1			
Flathead			5									1	1			
Gallatin	1	15	3						1				2			
Garfield																
Glacier			11				1							2		
Golden Valley														1		
Granite																
Hill			4					1								
Jefferson																
Judith Basin				1												
Leke			3					1								
Lewis & Clark	1	14	2						2			1	2	1		
Liberty																
Lincoln	2				1									1		
McCone																
Medison																
Meagher																
Mineral																
Missoula	4	18	5			1							3	2		2
Musselshell																
Park	1	6														
Petroleum																
Phillips														1		
Pondera			1													
Powder River																
Powell			1													
Prairie																
Ravalli			1										1	1		
Richland							1							1		
Roosevelt			8	1	1		1									
Rosebud							1									
Sanders			1			1										
Sheridan																
Silver Bow			5						1	1		1				
Stillwater				1	1											
Sweet Grass			1													
Teton																
Toole																
Treasure																
Valley																
Wheatland																
Wibaux																
Yellowstone		3	40	2			1	1						1	11	
MONTHLY TOTAL	1991	13	168	19	3	2	5	4	4	1	0	7	12	11	13	3
	1990	5	154	10	25	1	20	5	1	0	0	11	7	9	3	12
	1989	21	104	24	19	2	11	4	2	0	0	17	7	11	4	0
	1991	64	994	85	63	6	65	45	18	6	9	59	31	87	25	9
TOTAL TO DATE	1990	65	1051	101	148	9	87	48	5	4	10	58	39	73	29	18
	1989	46	803	71	120	5	31	33	3	2	1	50	55	36	89	12
OTHER DISEASES:		Bact. Mening. Unspec.:				E.COLI, O157:				COLORADO TICK FEV.						
Aseptic Meningitis:		Cascade-1				Flathead-1				Beaverhead-1						
Yellowstone-1		Legionellosis: Blaine-1				L & C Co. -1				Park-1						
Rocky Mtn. Spotted Fever:		Missoula-1				Mineral-1				Ravalli-1						
Yellowstone-1		Toxic Shock Syndrome:				Missoula-1				Silver Bow-1						
		Richland-1														

MISCONCEPTIONS ABOUT CONTRAINDICATIONS
TO IMMUNIZATION

Many parents and some physicians inappropriately consider certain conditions or circumstances to be contraindications to immunization. As a result, some children miss scheduled immunizations, and are at risk for developing easily preventable diseases. NONE OF THE FOLLOWING CONDITIONS SHOULD PRECLUDE AN OTHERWISE HEALTHY CHILD FROM BEING VACCINATED:

- Reaction to a previous dose of DPT vaccine that involved only soreness, redness or swelling in the immediate vicinity of the immunization site (local reaction), or temperature less and 40.5° C (105° F)
- Mild acute illness with low-grade fever or mild diarrheal illness
- Current antibiotic therapy
- Prematurity
- Weight <4.5 Kg (10 pounds)
- Pregnancy of mother or other household contact

- Allergies to penicillin or other antibiotics, eggs*, or nonspecific environmental allergens
- Family histories of seizures, sudden infant death syndrome, or adverse event following vaccination

*Persons with egg allergies that are not anaphylactic in nature may be vaccinated in the usual manner. Persons with a history of anaphylactic reactions to eggs, however, should be vaccinated only with extreme caution. Protocols have been developed for vaccinating such persons.

REVIEW OF DRAFT GUIDELINES
FOR HIV TESTING SERVICES FOR PATIENTS
IN ACUTE-CARE HOSPITAL SETTINGS

The Centers for Disease Control is updating guidelines for HIV testing services for patients in acute-care hospital settings. This draft document is available for review from the National AIDS Clearinghouse, P.O. Box 6003, Rockville, MD 20849-6003; phone (800) 458-5231. Written comments on these proposed guidelines should be sent to the same address by October 21, 1991.

Volume: 15:8

Month of: AUGUST, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

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Morbidity Report

VOL. 15 NO. 9

September 1991

Montana State Department of Health and Environmental Sciences

RUBELLA ALERT

Montana's first cases of rubella in 1991 have recently been reported to the State Department of Health and Environmental Sciences. The initial case was a 4-year-old boy from Gallatin County who presented on 10/11/91 with a typical diffuse rash and coryza. Interestingly, other rubella symptoms including fever and swollen glands did not develop in the boy. The subject was unimmunized. The diagnosis of rubella was serologically confirmed by the State Public Health Laboratories. Three additional cases of rubella are currently under investigation by DHES workers.

Patterns of disease due to rubella in Montana have been very inconsistent over the years. During the decade of the 80's, no reports of disease were recorded for six of the ten years. Clusters of cases, however, have occurred during several of the last 10 years. The most recent outbreak being an 11-case cluster in Gallatin County in 1990. A record-high number of

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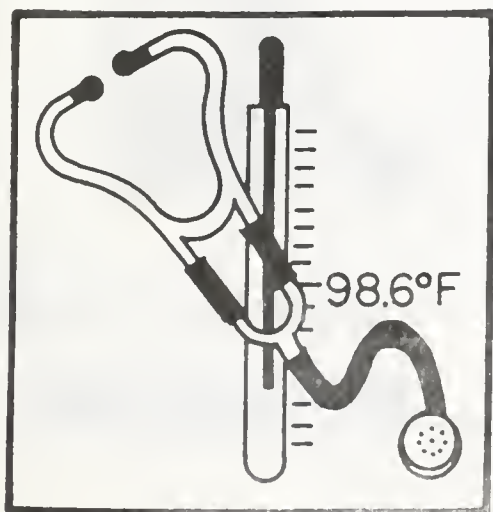
annual cases in Montana was reported last year. State health officials are concerned about the recent increased incidence of rubella, and are trying to heighten health worker's awareness of this illness.

Rubella can often be overlooked or misdiagnosed because its signs and symptoms vary, and may be confused with a number of other illnesses. The common manifestations of disease, lymphadenopathy, muscle aches, transient rash, and low fever are not always present.

Similar rash illnesses can be caused by a variety of other viral agents. Thus, clinical diagnosis of rubella is often inaccurate. All cases should be laboratory confirmed, particularly outside the outbreak setting.

The most important consequences of rubella are the miscarriages, stillbirths, fetal anomalies, and therapeutic abortions that result from rubella infection in early

Continued on Page 2



pregnancy, especially in the first trimester. It has been estimated that the lifetime cost associated with the special medical and educational needs of each child born with congenital rubella syndrome is in excess of \$200,000. Preventing fetal infection and consequent congenital rubella syndrome is an objective of the state's Immunization Program.

All non-immune individuals should be vaccinated. To be considered immune to rubella, a person must meet one of the following two conditions:

- History of laboratory-confirmed, physician's diagnosis of rubella infection
- Adequate immunization with at least one dose of rubella vaccine on or after the first birthday.

MDHES recommends 2 doses of MMR vaccine, separated by at least one month, with the first dose given after 15 months of age

MDHES requests that all rash illnesses with cold symptoms be reported immediately to your county health department, and that laboratory specimens be submitted to the Montana State Public Health Lab whenever possible. For information on submission of specimens to MDHES for analysis, contact the public health lab at 444-3444.

1991 RED BOOK AVAILABLE

The American Academy of Pediatrics (AAP) has released the 1991 edition of the **Report of the Committee on Infectious Diseases** (the Red Book). The Red Book is an excellent resource for the control and management of infectious diseases in children. It also provides detailed recommendations regarding childhood immunizations. Copies may be purchased from the American Academy of Pediatrics, Attention: Publications, 141 Northwest Point Blvd., Elk Grove Village, Illinois 60007. Telephone (800) 433-9016. Cost per copy is \$45.00 plus \$5.75 shipping/handling. Discounts are available to AAP members and for volume purchases.

INFLUENZA VACCINE UPDATE

The trivalent influenza vaccine prepared for the 1991-92 season includes A/Taiwan/1/86-like (H1N1), A/Beijing/353/89 (H3N2), and B/Panama/45/90-like antigens. It is expected that A/Beijing will be the predominant subtype circulating.

The influenza season is generally between late fall and early spring, with the greatest risk of infection occurring in December, January, and February. The optimal month for vaccination is usually November.

Influenza vaccine is strongly recommended for anyone age 65 or older, and those under 65 with certain chronic diseases. Health care providers, because of their close contact with high-risk persons, should also be immunized. In addition, influenza vaccine may be given to anyone wishing to reduce their chances of contracting influenza. Influenza vaccine should NOT be given to persons who have severe allergies to eggs. Persons with acute febrile illnesses usually should not be given the vaccine until they recover.



LEAD POISONING ALERT

The National Institute of Occupational Safety and Health issued an alert on October 22, 1991, to warn construction workers that they may be at risk for lead poisoning during work on bridges or other steel structures coated with lead-containing paint. The Alert, entitled Request for Assistance in Preventing Lead Poisoning in Construction Workers, describes 42 cases of lead poisoning that occurred recently during work at eight different worksites. The actual number of lead poisoning cases nationwide may be much larger since employers are not required to routinely measure blood lead levels of exposed construction workers, and many cases may therefore go unreported. The NIOSH Alert describes the lead hazards faced by construction workers, and recommends methods for reducing or eliminating them. For copies of this alert and other NIOSH documents, contact;

Publications Dissemination, DSDTT
National Institute for Occupational
Safety & Health
4676 Columbia Parkway
Cincinnati, Ohio 45226
(513) 533-8287



CHEMOPROPHYLAXIS OF PERTUSSIS

The Immunization Practices Advisory Committee (ACIP) has recently expanded their recommendations for chemoprophylaxis of pertussis case contacts to include all household and other close contacts, regardless of age or vaccination status. Previously, chemoprophylaxis was recommended only for children under 7 years of age. A regimen of erythromycin or trimethoprim/sulfamethoxazole (TMP/SMX) will prevent or minimize transmission of Bordetella pertussis from cases to case-contacts and from case-contacts to uninfected persons. The new ACIP position is consistent with recommendations of the American Academy of Pediatrics, and the American Public Health Association.



Recommended prophylactic regimens (all 14-day) for contacts of persons with pertussis are as follows:

Pediatric: erythromycin (40 mg/kg/d) or TMP/SMX (TMP, 8 mg/kg/d; SMX, 40 mg/kg/d)

Adult: erythromycin (1 g/d) or TMP/SMX (TMP, 320 mg/d; SMX, 1600 mg/d)

TMP/SMX may be employed in instances of erythromycin intolerance. For children under seven years of age, proper management also includes ensuring that DTP immunizations are current.

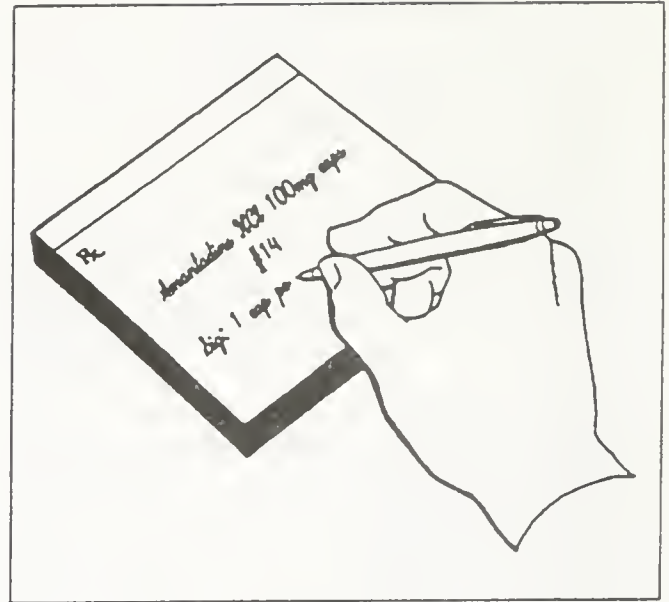
AIDS Briefs

- It is expected that the Social Security Administration will propose a revised system to facilitate receiving disability benefits for HIV-infected persons early this fall, to become effective January 1. This system is expected to tie presumptive disability directly to an individual's medical condition, regardless of the presence or absence of CDC-defined AIDS.
- According to estimates provided by New York City to the New York Times, "by 1993, 20,000 children in New York City will have lost their mothers to AIDS."
- According to the Coalition for Consumer Health and Safety, "medical care costs related to HIV were an estimated \$4.7 billion in 1990. Enduring costs, such as productivity loss, are estimated to be \$55.6 billion in 1991."

(From Association of State and Territorial Health Officials, Vol.2, Number 9, September 1991)

ATTENTION ALL PUBLIC VACCINE PROVIDERS

If you have not placed your fall vaccine order, please do so within the next month. We would prefer not to ship vaccine during December and January, if possible. Please call Liz at 444-5580 if you have any questions.



UNAVAILABILITY OF STREPTOMYCIN AND PARA-AMINOSALICYLIC ACID

Streptomycin (SM) and para-aminosalicylic acid (PAS), antimicrobial agents used to treat tuberculosis (TB), are currently unavailable in the United States. Because of problems in the supply of bulk SM, which is produced outside the United States, the U.S. manufacturer has ceased production of the finished product. The U.S. manufacturer of PAS has voluntarily discontinued production on a temporary basis. Although CDC and the Food and Drug Administration are attempting to reestablish production of these drugs, health-care providers should be prepared for an interruption in their supply.



MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of September 30, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	44 (42)	33 (75)	1 (50)	1 (100)	45 (42)	34 (76)
Other Disease w/o PCP	61 (58)	37 (61)	1 (50)	0 (0)	62 (57)	37 (60)
KS Alone	1 (1)	0 (0)	0 (0)	0 (.)	1 (1)	0 (0)
No Diseases Listed	0 (0)	0 (.)	0 (0)	0 (.)	0 (0)	0 (.)
Total	106 (100)	70 (66)	2 (100)	1 (50)	108 (100)	71 (66)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	92 (87)	0 (0)	92 (85)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	31 (29)	Hispanic	4 (4)	0 (0)	4 (4)
30-39	44 (41)	Native American	7 (7)	2 (100)	9 (8)
40-49	21 (19)	Unknown	1 (1)	0 (0)	1 (1)
Over 49	8 (7)	Total	106 (100)	2 (100)	108 (100)
Unknown	0 (0)				
Total	108 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	65 (68)	0 (0)	65 (61)
Intravenous (IV) Drug User	11 (11)	1 (10)	12 (11)
Homo/Bi IV Drug User	10 (10)	0 (0)	10 (9)
Hemophiliac	5 (5)	0 (0)	5 (5)
Heterosexual Contact	0 (0)	6 (60)	6 (6)
Transfusion With Blood/Products	0 (0)	2 (20)	2 (2)
None of the Above/Other	5 (5)	1 (10)	6 (6)
Total	96 (100)	10 (100)	106 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
None of the above/Other	0 (0)	0 (0)	0 (0)
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through September 30, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of September 30, 1991 there have been 311 cumulative positive HIV tests from 28,960 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of August 31, 1991, 191,601 cases of AIDS and 122,905 deaths have been reported to the Centers for Disease Control.

Sep-1991

¹Includes 81 Montana AIDS cases and 27 cases reported to Centers for Disease Control from other states who moved to Montana.

SEPTEMBER 1991	Campylobacter, diarrhea	Chlamydia, sexually transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non A, Non B	Hepatitis, unspecified	Meningococcal meningitis	Post exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis	
Beaverhead	2	2														
Big Horn		15											1	1		
Blaine		5														
Broadwater																
Carbon																
Carier																
Cascade	1	31	6	6		1	2					1	1			
Chouteau	1	2														
Custer		1				1										
Daniels																
Dawson																
Deer Lodge		2	1													
Fallon																
Fergus		2										1				
Flathead		5	3										1			
Gallatin		22	1										2			
Garfield																
Glacier		7	1	2										1		
Golden Valley																
Granite			1													
Hill	1	12					1									
Jefferson																
Judith Basin		1														
Lake		4					1									
Lewis & Clark		9	2	1			2	1			1					
Liberty																
Lincoln		6														
McCone																
Madison																
Meagher																
Mineral	2															
Missoula	1	14	9	1			1	1					4	1		
Musselshell																
Park	1	1														
Petroleum																
Phillips						1							1			
Pondera		2														
Powder River																
Powell																
Prairie																
Ravalli			1		1						1	1				
Richland																
Roosevelt		7											1			
Rosebud		1	2				1									
Sanders																
Sheridan																
Silver Bow	2	10	1				1				2					
Stillwater		1										1				
Sweet Grass																
Teton		1	1													
Toole																
Treasure																
Valley													1			
Wheatland																
Wibaux																
Yellowstone		31	2	1		2	1						3	17		
MONTHLY TOTAL	19 91	11	194	31	11	1	5	10	2	0	0	4	4	15	20	0
	19 90	6	122	30	18	0	40	7	2	0	0	15	5	14	6	0
	19 89	17	122	28	20	0	24	2	0	1	0	7	6	5	20	0
TOTAL TO DATE	19 91	75	1188	116	74	7	70	55	20	6	9	63	35	102	45	9
	19 90	71	1173	131	166	9	127	55	7	4	10	73	44	87	35	18
	19 89	46	803	71	120	5	31	33	3	2	1	50	55	36	89	12
OTHER DISEASES:																
ASPETIC MININGITIS:																
Cascase - 1																
Gallatin - 2																
Yellowstone - 5																
PERTUSSIS: Hill - 1																
TULAREMIA: Lake - 1																
Yellowstone - 1																
ROCKY MTN SPOTTED FEVER:																
Custer - 1																
E. COLI 0157:																
Choteau - 1																
Flathead - 1																
Gallatin - 1																
Missoula - 1																

REPORTABLE DISEASES

DEPARTMENT OF HEALTH AND ENVIRONMENTAL SCIENCES

HEALTH SERVICES DIVISION

COGSWELL BUILDING

HELENA, MONTANA 59620

T = Immediately Telephone Case Report X = Report on Confidential Case Report Card	Telephone or Mail Daily	Mail Within 7 Days	Mail Weekly Numbers Only		Telephone or Mail Daily	Mail Within 7 Days	Mail Weekly Numbers Only
		X		Pertussis (whooping cough)	X		
	T			Plague	T		
		X		Poliomyelitis	X		
	T			Q-fever		X	
		X		Rabies or exposure (human)	T		
		X		Reye's Syndrome		X	
	X			Rocky Mountain Spotted Fever		X	
			X	Rubella (including congenital)	X		
		X		Salmonellosis		X	
	X			Shigellosis		X	
			X	Smallpox (including vaccinia)	T		
			X	Staphylococcal epidemic			X
		X		Streptococcal epidemic			X
	X			Syphilis	X		
	T			Swimmer's Itch			X
		X		Tetanus	X		
	X			Trichinosis		X	
		X		Tuberculosis		X	
	X			Tularemia		X	
	X			Typhoid fever	T		
	X			Typhus	X		
		X		Yellow fever	X		
		X		Yersiniosis		X	
		X		Illness in a foreign traveler	X		
		X		An unusual outbreak of any communicable disease	X		
		X					
			X				
		X					
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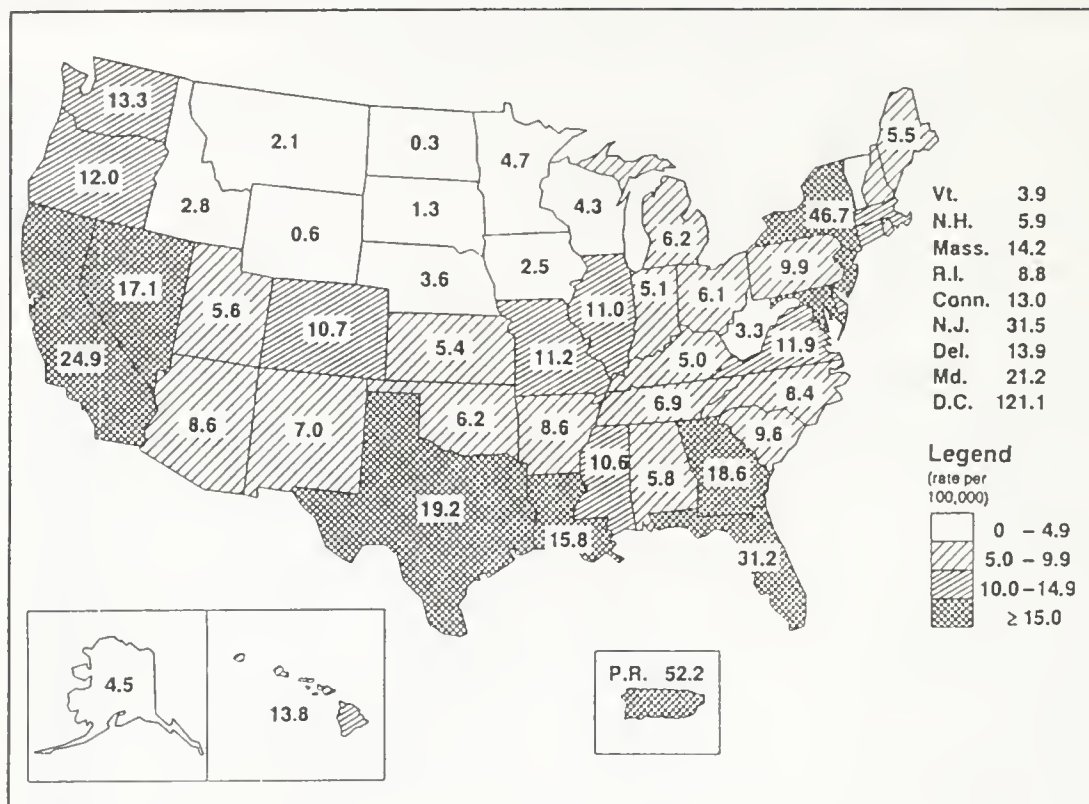
Report to your local health officer:

Name: _____

Phone: _____

If unable to contact local health officer, contact:
 STATE DEPT. OF HEALTH & ENV. SCIENCES
 Cogswell Bldg.
 Helena, MT 59620
 ATTN: Communicable Disease Control

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) — Cases per 100,000 population, reported to CDC by state, United States, 1990



Volume:

Month of:

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

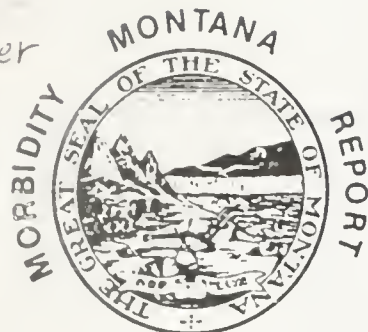
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VOL. 15 NO. 10

October 1991

Montana State Department of Health and Environmental Sciences

COMMUNITY OUTBREAKS OF SHIGELLOSIS MONTANA, 1991

The Department of Health and Environmental Sciences has identified several recent community outbreaks of shigellosis in Montana. Yellowstone County health officials have reported 41 culture-confirmed cases of shigellosis. Hill County has recorded 19 cases. Additional cases continue to be reported at this writing. Overall, 78 cases of disease have been identified so far this year among Montana residents. This total is larger than the year-end totals for eight of the previous ten years (see Fig. 1). The distribution of cases by county is shown in Figure 2. The distribution of shigellosis cases by age is shown in Table 1. It can be noted that the majority of cases are occurring among preschoolers. Sixty-seven percent of cases have been in Native Americans. Epidemiologic investigations have not identified a common source of infection. The findings, however, are consistent with person-to-person transmission. Such a pattern of disease, historically, has been common in Montana.

Communitywide outbreaks of shigellosis can be difficult to control because of the ease of person-to-person transmission among young children, high secondary attack rates and multiple points of exposure. The duration of these outbreaks is frequently extended.

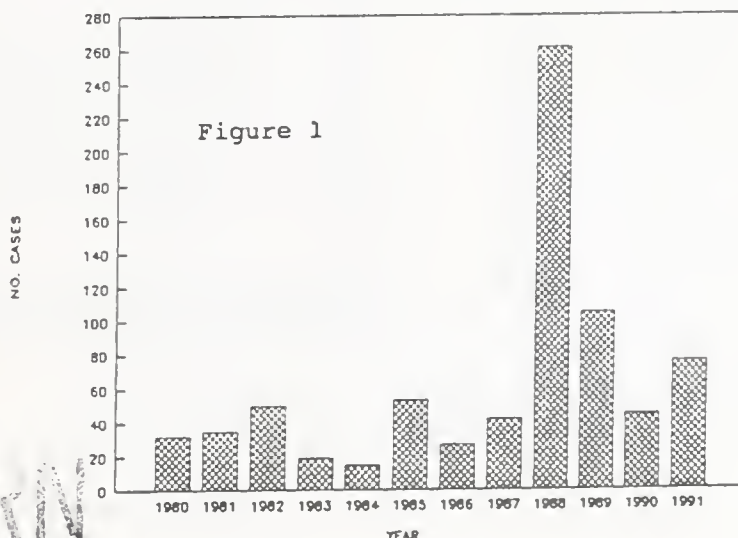
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Control efforts should include the following: 1) communitywide recognition of the problem, 2) educational efforts to promote handwashing and hygiene, and 3) supervised handwashing for children.

(continued on page 3)

SHIGELLA CASES, MONTANA, 1980-DATE



SHIGELLOSIS CONTROL

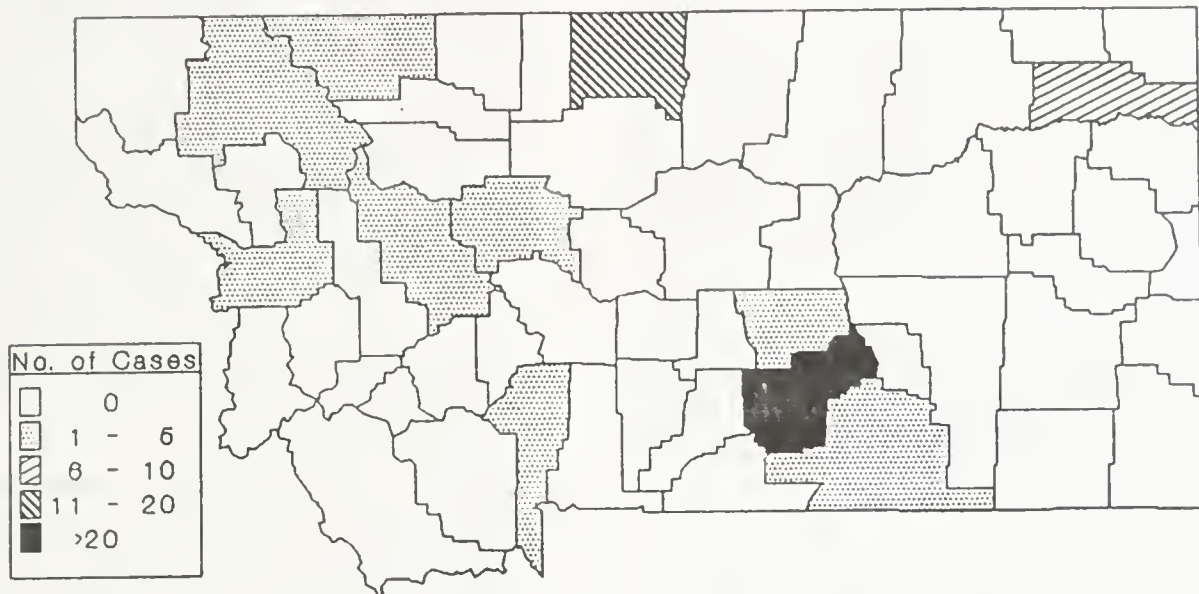
TIPS & IDEAS

- Provide information about shigellosis and its prevention to child-care center, preschool and nursery school employees, and to parents of children in school where cases are occurring.
- Suggest that schools assign a teacher to monitor handwashing by young students before lunch.
- Forbid home-prepared foods at any school or child-care events.
- Have school officials in affected areas ensure that warm water, soap, and disposable towels for handwashing are always available for students.
- Have parents and teachers provide instruction to students on proper handwashing techniques.
- Provide printed educational materials about shigellosis to persons attending WIC clinics, immunization clinics, community clinics, and hospital emergency rooms.
- Arrange for the health department to conduct periodic sanitation inspections of schools.
- Disseminate information regarding proper diaper-changing practices among nursery schools and day-care centers.
- Contact families of cases to identify potential exposures and secondary cases, and to encourage hygiene and handwashing.
- Encourage physicians, hospitals, labs, etc., in the area to assist in identifying and reporting new cases.
- Assist tribal leaders in providing information in tribal newsletters and at informal gatherings.
- Prepare press releases to local newspapers and radio stations.
- Notify restaurants, lodges, and other eating establishments of the importance of excluding symptomatic persons from food handling duties.

Figure 2

SHIGELLA CASES BY COUNTY

Montana, 1/1/91-10/31/91



Handwashing with soap and warm water may be the single most important preventive measure to interrupt transmission of shigellosis. Because young children are most likely to be infected, and transmit disease to others, a strict policy of supervised handwashing for young children after defecation and before eating is crucial. Daycare centers, preschools, homeless shelters, and other institutions where hygiene may be suboptimal should be targeted for control efforts.

Antimicrobials have a very limited role in the control of epidemic shigellosis, and are not a substitute for hygienic measures. Prophylactic use of antimicrobials cannot be recommended to prevent illness in persons who are exposed but not ill. In addition, using antimicrobials to treat patients with mild disease to reduce the spread of secondary infections is not known to be any more effective in preventing shigellosis than handwashing with soap and water; moreover, this practice can lead to the development of resistant strains that complicate therapy.

Outbreaks of shigellosis can occur at any time of the year. While most cases occur in the summertime, case reports in Montana are peaking at this time. Shigella infection should be considered in cases of diarrheal illness, particularly among young children. Stool specimens should be obtained, and the state and local health department notified promptly of culture-confirmed cases so that further outbreaks of shigellosis can be recognized, and appropriate control measures instituted.

Table 1. Distribution of Shigella Cases by Age, Montana, 1991 to Date

Age Group	N	%
< 5	31	39.7
6 - 10	6	7.7
11 - 20	5	6.4
21 - 30	5	6.4
31 - 40	5	6.4
41 - 50	4	5.1
> 50	3	3.8
(Unknown)*	19	24.4

*Unknown due to incomplete reporting.
(Health workers, help us help you!)

CHILDHOOD LEAD POISONING

Childhood lead poisoning is one of the most common pediatric health problems in Montana and the nation today. One out of six children has unacceptable levels of lead in their bodies. Significant lead exposure at a young age can cause brain damage, short attention span, and lower IQ. Lead has also been linked with difficulties in learning language. Exposure during pregnancy can jeopardize fetal development. At high doses, some signs of childhood lead poisoning are hyperactivity, emotional outbreaks, lack of attention, fatigue, delinquency, loss of coordination, pain and soreness.

New data indicate significant adverse effects of lead in children at blood levels previously believed to be safe. Previous lead statements issued by the Centers for Disease Control (CDC) have acknowledged the adverse effect of lead. In the past several years, however, the scientific evidence showing adverse effects at blood levels of 10 ug/dl and lower has become so compelling that it has forced health authorities to redirect, and increase attention on this disease.

The Department of Health and Environmental Sciences regularly receives reports of elevated blood levels of lead in children throughout the state. Several studies have been conducted in Montana to determine the sources of exposure to lead. Most of these studies attempted to detect associations between industrial/ mining activities and elevated blood levels in man. These studies have shown lead-based house paint to be the primary source of lead associated with elevated blood lead levels.

Lead is widespread in our environment. It has no known physiologic value. Children are particularly susceptible to lead's toxic effects. Lead poisoning, for the most part, is silent: most poisoned children have no symptoms. The vast majority of cases, therefore, go undiagnosed and untreated. Lead poisoning is widespread. It is not solely a problem of big city children. No socioeconomic group, geographic area, or racial or ethnic population is spared. The persistence of lead poisoning in our nation presents a singular and direct challenge to public

health authorities, clinicians, regulatory agencies and society.

The Centers for Disease Control this month released the document, **Preventing Lead Poisoning in Young Children**. This document provides guidelines on preventing and treating childhood lead poisoning. It is intended for diverse groups including public health officials, pediatricians, government agencies, and concerned citizens. Pediatricians and other health-care practitioners can use this document for information on laboratory testing, and the medical treatment of poisoned children. Government agencies, officials, and citizens can obtain information about what constitutes a harmful level of lead in blood; what the current definition of lead poisoning is, and what blood lead levels should trigger environmental and other interventions.

Copies of the document **Preventing Lead Poisoning in Young Children** are available from Publication Activities, Office of the Director, National Center for Environmental Health and Injury Control, CDC, MS-F29, 1600 Clifton Road, Atlanta, GA 30333.



According to the American Lung Association of Montana, the use of smokeless tobacco products has grown rapidly in recent years. Most alarming is the fact that while the percentage of adult users has remained constant between the years 1970-1985, the percentage of teenagers who using smokeless tobacco has increased markedly.

A July 1991 survey of Montana students in grades 9-12 indicated that 48.1% of females and 56.1% of males have tried smokeless tobacco or planned to try it in the future. Still more disturbing was the finding that 33% of males had used smokeless tobacco within the past 30 days.

It is clear that a problem exists with Montana teenagers and their use of tobacco products. The ALA of Montana is gearing up its programming efforts to reach these kids before they get hooked on nicotine and to provide them with straight answers regarding drug addiction and tobacco industry advertising campaigns. For more information on this program, call the Montana Lung Association at 1-800-252-6368.

CONGRESS DEFEATS MANDATED HEALTH WORKER HIV TESTS

In October, Congress reversed attempts to mandate testing of health care workers for HIV, replacing it with a measure that would require state health departments to adopt the Centers for Disease Control testing guidelines or some "equivalent" standards.

CDC guidelines set out in July urge health professionals to be voluntarily tested for the virus but the statements rejected any need for mandatory testing. The new bill would require state health officers to certify measures were being taken to prevent transmission from health care worker to patient. Enforcement would be left to the states. If the state program was not approved by CDC the state would then be cut off from funding under the Public Health Service Act.

On other issues, the Senate has called for final adoption of the OSHA blood-borne standards which were requiring an adoption by December 1.

Montana State health officials have been notified of several cases of illness clinically consistent with influenza in Eastern Idaho. Laboratory confirmation, however, has not yet been attempted. The Centers for Disease Control has predicted the early appearance of influenza this season. Local health departments are urged to submit clinical samples early this year in order to identify the predominant type as soon as possible. Confirmation of influenza is made during early stages of disease by isolation of a virus from pharyngeal secretions or washings during the early febrile stage of disease. Infection may also be confirmed by demonstration of a specific serologic response in acute and convalescent sera. **Remember, November is the time to administer influenza vaccine.**

Be a fighter.
Knock out
the

FLU
before the
Flu knocks
you!



Get a flu shot!
It's a matter of life and breath*

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HIV COUNSELING AND TESTING
MONTANA, 1989 AND 1990

The Montana Department of Health and Environmental Sciences AIDS/STD Program prevention activities include the support of public, anonymous HIV counseling and testing. The Department's Public Health Laboratory conducts the testing and also compiles and analyzes test results. Included in this data is information about: 1) numbers of tests and positive results, 2) breakdown of tests and results by self-reported risk category, and 3) breakdown of tests and results by type of provider age group, sex and race/ ethnicity. Personal identifiers do not exist in these data files. A report summarizing the data reported for 1989 and 1990 has been prepared, and is available by calling Kathy Anderson at (406) 444-2678. Selected results will be featured in future issues of Montana's Morbidity Report. Also, in January 1992, MDHES will be introducing a new laboratory slip for HIV antibody testing to be used by any health care provider submitting specimens to the Public Health Laboratory for testing.

HIV CONFERENCE SCHEDULED

The Seventh Annual Rocky Mountain Regional Conference on HIV Disease: The Challenge of the Second Decade is scheduled for February 7-8, 1992, at the Red Lion Hotel in Denver, Colorado. The conference sponsors include the Colorado AIDS Education and Training Center; the Colorado AIDS Project; the Colorado Department of Health-STD/AIDS Section; and the Denver Department of Health and Hospitals-Denver Department of Public Health. Registration is \$95.00 for registrations postmarked by December 31, 1991; \$80.00 per participant for organizations registering five or more members in the same envelope postmarked by December 31, 1991. For more information, contact Peter Ralin at (303) 893-6300 or Terry Stewart at (303) 837-0166.

CancerFax™, a new service that provides treatment guidelines from the National Cancer Institute's PDQ (Physician Data Query) database, enables NCI to send the latest updates on cancer treatment to any health care professional who has a fax machine.

The service is available 24 hours a day, seven days a week. The only cost involved is a telephone call to the CancerFax™ computer, (301) 402-5874, in Bethesda, Maryland. An automated voice system directs callers in getting the information they want.

For more details about this service, contact the NCI Office of Cancer Communications, Building 31, Room 10A24, Bethesda, MD 20892; (301) 496-6641.

No Matter What Shape You're In,
Anyone Can Get The AIDS Virus.



These days, people all over America are working on their bodies. These are active people with active social lives. If that sounds like your lifestyle, think about this: One workout that can protect you from the AIDS virus is just to be responsible and not to take risks when it comes to sex.

For more information about AIDS, call 1-800-342-AIDS.

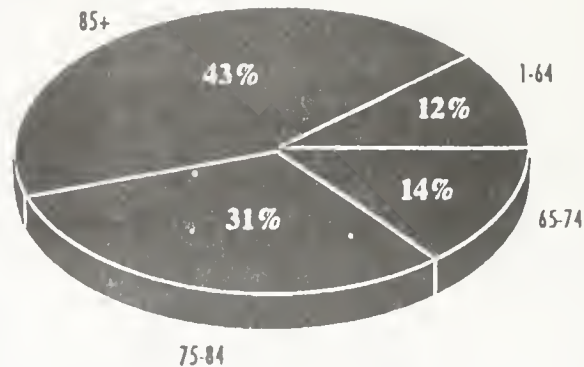


This is a message from the U.S. Centers for Disease Control

October 1991		Campylobacter, diarrhea	Chlamydia, sexually-transmi	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatm	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			6													
Big Horn			1													
Blaine																
Broadwater																
Carbon			1											2		
Carler																
Cascade			7		1									1		
Chouteau																
Custer			2													
Danels																
Dawson														2		
Deer Lodge			2					1								
Fallon																
Fergus			2													
Flathaad			4													
Gallatin			10											1	1	
Garfield																
Glacier				1			2									
Golden Valley																
Granite				3												
Hill			2											1	8	
Jefferson																
Judith Basin																
Lake														3		
Lewis & Clark			6											1	1	
Liberty																
Lincoln			2													
McCone																
Medison																
Meagher																
Mineral		1														
Missoula			25	3										3		
Mussetshell																
Park																
Petroleum																
Phillips			1				1						1			
Pondera													1			
Powder River																
Powell																
Prairie																
Ravalli																
Richland																
Roosevelt				1											2	
Rosebud																
Sanders																
Sheridan																
Silver Bow			5											1		
Sillwater																
Sweet Grass																
Teton									1							
Toole																
Treasure																
Valley																
Wheatland																
Wibaux						1										
Yellowstone			34		1		1	1						1	6	
MONTHLY TOTAL	19 91	1	115	8	2	1	4	2	1	0	0	0	2	16	18	0
	19 90	4	149	15	26	1	21	6	0	0	0	2	5	16	3	0
	19 89	6	144	29	18	2	14	2	0	0	1	9	1	24	2	5
TOTAL TO DATE	19 91	76	1303	124	76	8	74	57	21	6	9	63	37	118	78	9
	19 90	75	1322	146	192	10	31	61	7	4	10	75	44	103	38	18
	19 89	46	803	71	120	5	25	33	3	2	1	50	55	36	89	12
OTHER DISEASES:																
CHICKENPOX: Cascade-1																
PERTUSSIS: Hill-1																
LEGIONELLA: Big Horn-1																
BAC. MENING. UNSPEC. Glacier-1																

FLU TAKES ITS TOLL

The pie chart at right shows the percentage of flu and pneumonia deaths among different age groups in the U.S. in 1988. While the risk of dying from either condition is highest among the elderly, 9,300 Americans age 62 or younger succumbed to flu or pneumonia that year.



Volume: 15: No. 10

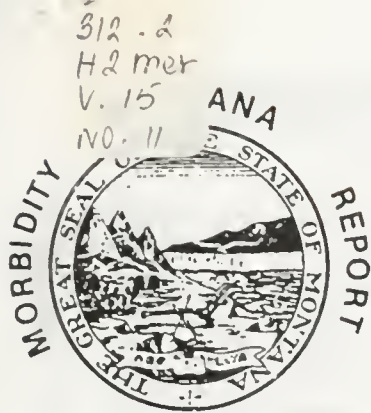
Month of: October, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

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POSTAGE PAID
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1200 copies of this public document are published monthly at an estimated cost of 37¢ per copy, for a total cost of \$435.00, which includes \$300.00 for printing and \$135.00 for distribution.



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VOL. 15 NO. 11

November 1991

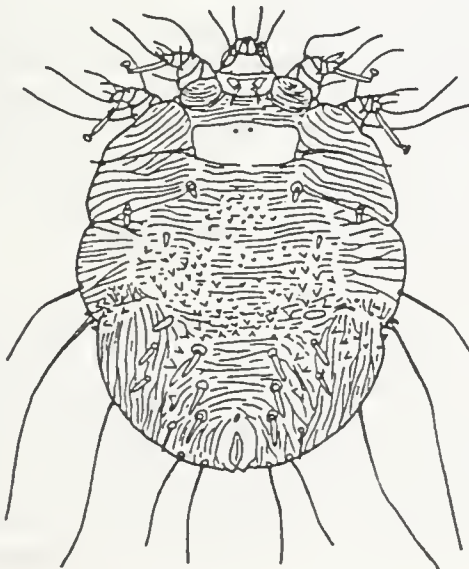
Montana State Department of Health and Environmental Sciences

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Toole County health officials notified the State Department of Health and Environmental Sciences that more than 170 cases of scabies infection had been identified in area school children as of November 21, 1991. The outbreak was unusual in that cases presented with infestation confined exclusively to the scalp an uncommon site of infestation by the scabies mite. The involvement of the head louse, Pediculus capitis, in the outbreak was ruled out by physicians attending to cases. Despite prompt and proper control measures, occurrences and recurrences were noted over a 3-4 week period. Community concern, media attention, school administration involvement, and public health activities were at high levels during this time.



Scabies is a parasitic disease of the skin caused by the mite Sarcoptes scabiei. The disease is generally first recognized with the occurrence of an intense itch and papular skin eruption.

In adults and older children the mites dig burrows in the skin folds between the fingers, around wrists, elbows, axillary folds, thigh, belt line, and external genitalia in men; and frequently occur on the abdomen, nipples, and lower buttocks in women. Infants are likely to have vesicular skin eruptions on the head, neck, palms and soles.

The itching associated with the burrows is especially intense at night, but complications are limited to secondary infection of lesions due to scratching. In immunocompromised individuals the infection is widely distributed and is accompanied by scaling, vesiculation and crusting ("Norwegian Scabies"), although the itching may be less severe or absent.

(continued on page 2)

Scabies infections have been attributed in the past to poor hygiene, poverty and overcrowding. However, scabies has recently been shown to affect every socioeconomic group, age, sex, and race, regardless of personal hygiene practices.

Transmission of scabies mites occurs by direct skin-to-skin contact or through sexual contact. Scabies mites can not live for extended periods away from human skin. As a result, scabies cannot be transmitted by clothing or bedding unless those items were contaminated by infested persons immediately beforehand.

Most people who are having their first exposure to scabies have been infected for 2 to 6 weeks before the start of itching and skin eruptions. Infested persons can transmit mites unless they have undergone a successful treatment regimen. The recommended treatment for scabies is the application of a 5% permethrin cream (eg. ElimiteTM). Recent studies have shown that permethrin-based creams provide a higher cure rate, and are less toxic than lindane-based lotions. Itching may persist for 1-2 weeks but should not be interpreted as a treatment failure.

School children who are diagnosed with scabies should be excluded from school until 1 day after treatment. Concurrent high-temperature washing and drying of hats, clothing and bedding used within the last 48 hours by an infested person is expected to be of value in preventing reinfestation.

The outbreak situation in Toole County, largely, has been controlled. Sporadic cases, however, continue to be reported. Despite repeated sampling attempts, laboratory identification of an ectoparasite has not been achieved. Health care workers throughout Montana are urged to quickly report suspect cases of scabies among school children to the State Epidemiologist at 444-3986.

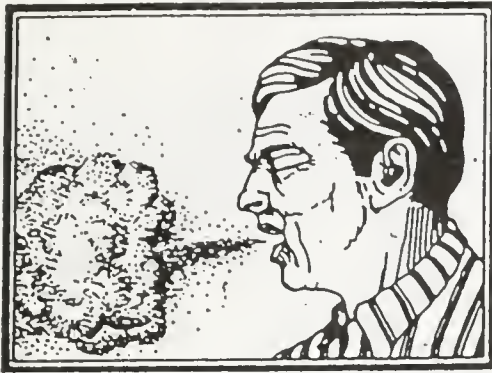
INFLUENZA UPDATE MONTANA, 1991-1992

Montana's first laboratory-confirmed case of influenza in the 1991-92 season was recorded by the Public Health Laboratory on December 2, 1991. Influenza virus type A was isolated from a 14 year old female student in Helena who was ill with symptoms of influenza. To date, a total 20 cases have been confirmed in Montana (Helena-8; Bozeman-4; Havre-4; Chester-2; Missoula-1; Dillon-1). All isolates have been identified as type A. Isolates have been recovered from a wide range of age groups. There is no indication that this virus differs from the strains used in the current vaccine, and persons who received influenza vaccinations this year should be well protected.

Several reports of influenza vaccine shortages around the nation have received media attention. The early arrival of influenza, and high morbidity rates in some states may have contributed to an unanticipated demand. The State Immunization Program confirms that vaccine supplies at local and county health departments in Montana are either exhausted or, at best, very limited. Vaccine manufacturers produced and distributed over 32 million doses of vaccine to private sector health care providers. This was an increase in distribution of 13 percent over 1990. Providers should contact either their local public health agency, or private sector provider for vaccine availability.

Some health officials fear that this may be a worse than average year for influenza (in contrast, the 1990-91 season was characterized as one of the mildest in decades). While the 1991-92 season got off to a faster start than usual, it is still too early to determine the severity and impact of the illness.

(continued on page 3)



Surveillance shows that the dominant circulating viruses at this time are influenza A. Physicians are reminded that influenza A virus infections can be prevented or ameliorated with amantadine hydrochloride.

Given within 48 hours after onset of symptoms, it can shorten the duration of illness and reduce the severity of symptoms. Amantadine may be indicated in the prophylaxis and treatment of patients outbreaks of influenza A virus infection can cause substantial morbidity and mortality among residents of nursing homes. The drug is not effective against type B influenza. Amantadine hydrochloride is available by prescription.

The Department of Health and Environmental Sciences is continuing to monitor influenza-like illnesses throughout the state. DHES has recently expanded its influenza surveillance activities to include school absenteeism recording as a component this seasons efforts.

A mini-poster shown on p. 9 has been produced by the National Institutes of Health, and describes flu versus cold symptoms. For a free copy, write to: Flu/HL, National Institutes of Health, Building 31, Room 2B23, Bethesda, MD 20892, or FAX 301-402-0395.

MISSED OPPORTUNITIES

Increases in measles morbidity can be traced to delays in receipt of vaccine. According to the "measles white paper," approximately 50% of the 1989 and 1990 measles cases occurred among unvaccinated preschool children. (Reference: National Vaccine Advisory Committee. The measles epidemic: the problems, barriers, and recommendations, 1991)

As an example of how opportunities are missed, consider the following true story which occurred recently.

"Billy needs his shots to get into school." The young mother shifted her second child (a sleepy little girl) in her arms as she produced the receipt for the nurse.

The nurse inspected the receipt, noting that the mother had paid her \$5.00 fee, and then turned her attention to the young boy and his shot record. After finding no contraindications, the nurse immunized the boy and instructed the mother to bring him back for the TB skin test to be read.

What about the second child? The sleepy little girl in the young mother's arms? The little 18-month-old girl who had only received the initial doses of DTP and OPV at 2 months of age? The second child which the young mother felt she could not afford to have immunized? Answer: She left the clinic unvaccinated, unprotected from a number of serious diseases including an emerging measles outbreak. An "opportunity" was missed.

The expression "missed opportunity" is being heard more and more these days. Despite adequate supplies of vaccines, distribution of information to every new mother, and little organized parental or religious opposition, our programs have failed to keep our preschool children adequately immunized. Epidemics of measles have produced embarrassingly high numbers of cases in many areas. Pertussis continues to claim lives. Young mothers remain susceptible to rubella.

How can we prevent these "missed opportunities?" Consider the following suggestions:

1. Administer as many vaccines as possible at one clinic visit. We should require, not recommend, that clinic personnel administer DTP, MMR, HibCV, and OPV at one visit if the patient is unimmunized for these antigens.

2. Avoid the "assembly line" trap. A few extra minutes could ensure that two children leave with vaccine, saving time for everyone involved, and most importantly, preventing additional illness.
3. Avoid the "dollar" barrier. If a parent has no money, we are required by law to provide vaccine anyway. No child is to be denied vaccine in clinics receiving federal funds or vaccine.
4. Discontinue the routine practice of immunizations by clinic appointment. Implement walk-in clinics for immunizations.
5. Increase or reschedule existing clinic hours to include evening clinics and weekend clinics.
6. Provide immunizations in alternative community settings. Do not depend on the unimmunized to attend the public health system "fixed" clinic sites.
7. Make sure communities know where and when immunizations are available at low or no cost for those who cannot afford them.
8. Assure that all clinic providers understand what constitutes a true medical contraindication to vaccine and that immunizations are not denied for the wrong reasons (eg., prematurity or weight).

It may seem ludicrous to "drum up" more business when our clinics are already full, but putting vaccine into kids is what we are all about.

The following conditions are **NOT** contraindications to immunization:

- o Reaction to a previous dose of DTP vaccine that involved only soreness, redness, or swelling in the immediate vicinity of the vaccination site or temperature of $<105^{\circ}\text{ F}$ (40.5° C).
- o Mild acute illness with low grade fever or mild diarrheal illness in an otherwise well child.

- o Current antimicrobial therapy of the convalescent phase of illnesses.
- o Prematurity or low weight. The appropriate age for initiating immunizations in the prematurely born infant is the usual chronological age. Vaccine doses should not be reduced for preterm infants.
- o Pregnancy of mother or other household contact.
- o Recent exposure to an infectious disease.
- o Breastfeeding. The only vaccine virus that has been isolated from breast milk is rubella vaccine virus. There is no good evidence that breast milk from women immunized against rubella is harmful to infants.
- o A history of nonspecific allergies or relatives with allergies.
- o Allergies to penicillin or any other antibiotic, except anaphylactic reactions to neomycin (e.g., MMR-containing vaccines) or streptomycin (e.g., OPV). None of the vaccines licensed in the U.S. contain penicillin.
- o Allergies to duck meat or duck feathers. No vaccine available in the U.S. is produced in substrates containing duck antigens.

- o Family history of convulsions in persons considered for pertussis or measles vaccinations.

- o Family history of sudden infant death syndrome in children considered for DPT vaccination.

- o Family history of an adverse event, unrelated to immunosuppression, following vaccination.

Reference:

National Vaccine Advisory Committee. The measles epidemic: the problems, barriers, and recommendations, 1991.

Reprinted from Texas Preventable Disease News, November 16, 1991.



AIDS BRIEFS

-The Delaware AIDS Program Office recently released results of its retrospective study of 2,045 patients who had received dental services from a dentist who died of AIDS earlier this year. None of the 628 patients who chose to be tested have tested positive for the human immunodeficiency virus. As of this writing, there have been no documented cases of HIV transmission from HCWs to patients subsequent to the Florida case. Over 9,000 patients throughout the country who have received treatment from infected health care workers have been tested to date.

-According to the Agency for Health Care Policy and Research, lifetime costs for a patient diagnosed with AIDS during 1991-1994 will be \$85,333. Treating each HIV-infected individual prior to an AIDS diagnosis will average \$5,150 annually. Private insurance covers 29% of persons with AIDS. 40% are covered by Medicaid, with 2 person having access to Medicare. The remaining 29% are uninsured.

-The Robert Wood Johnson Foundation projects that between 141,000 and 357,000 people will be under medical treatment for AIDS or HIV in 1992. By 1996 this number is expected to have increased by between 231,000 and 636,000.

-The U.S. Agency for International Development conducted an international conference on AIDS prevention in Washington, D.C. in November. Mrs. Museveni, the First Lady of the Republic of Uganda, reported that Uganda saw its first

AIDS case in 1983 and that coordinated prevention and intervention efforts were organized in 1986. Today, AIDS has become a critical problem throughout Uganda, with some urban areas reporting AIDS in up to 24% of the population. Over 80% of the AIDS cases in Uganda are transmitted heterosexually; 7% of children under 15 years of age were orphaned by the disease in 1990; 40% of hospital beds and 80% of TB beds are occupied by persons with AIDS.

HIV TITLE II INFORMATIONAL HEARING

The Montana Department of Health and Environmental Sciences announces an informational public hearing to solicit input on it's Title II Comprehensive Plan, which describes the proposed use and distribution of federal grant funds received under of the Ryan White Comprehensive AIDS Resources Emergency Act. The grant is to improve the quality, availability and organization of health care and support services for individuals and families with Human Immunodeficiency Virus infection.

The informational hearing will be held at 1:00 PM on Tuesday, January 28, 1992 in Conference Room C209, side 2 of the Cogswell Building, 1400 Broadway, Helena, Montana. A draft of the plan will be available and sent to selected agencies after 1/15/91 and can be requested by writing to Bruce Desonia, Montana Department of Health and Environmental Sciences, Cogswell Building, Helena, Mt. 59620. Written comments must be received by 1/31/91 to be considered in the application due 2/14/92.

The services available under the grant are establishment of HIV consortia, home and communitybased care, continuation of health insurance coverage, and provision of drug treatments. Currently \$60,000 has been allocated for consortia, \$30,000 for drug treatment and \$5,000 for insurance continuation. Under the new formula grant, \$100,000 will be available to Montana for the period 4/1/92 through 3/31/93.

PROPOSED CHANGES IN AIDS
CASE DEFINITION

The National Centers for Disease Control has revised its time line for the changes in the AIDS case definition and the classification of HIV infection. The changes reflect the increasing importance and widespread availability of CD4 testing.

The revision allows a period of comment, by anyone concerned, before the change officially occurs. At this time CDC does not anticipate implementing the new definition until April 1, 1992.

The proposed changes would include absolute CD4 counts less than or equal to 200/mm³ in the AIDS definition. If absolute CD4 counts are unavailable, a percentage of CD4 to total lymphocytes of 14% or less may be accepted. Changes in the classification of HIV infection do away with the prior system of classes and sub-classes and adopt a more concise system using CD4 counts and clinical symptoms.

If you are interested in receiving a copy of the draft please call Jim Murphy at 406-444-4744.

PRODUCT RECALL - PACIFIERS

Evenflo Products Company, Ravenna, OH and the U.S. Consumer Product Safety Commission have announced the recall of all Evenflo pacifiers decorated with Donald Duck, Daisy Duck, Mickey Mouse, or Minnie Mouse characters. In some instances, the characters can separate from the pacifier and present a choking hazard.

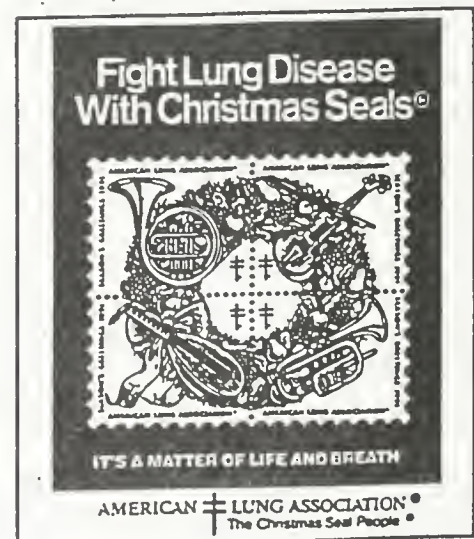
Evenflo sold the pacifiers between December 1990 and July 1991. Consumers having a pacifier decorated with one of these figures should discontinue use, and mail the pacifier to Evenflo Products Company, P.O. Box 1206, Ravenna, OH 44266-1206 and request replacement or refund. Customers may contact Evenflo at 1-800-356-2229.



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OR TOO EARLY.**

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your local American Lung
Association.

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November 1991		Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Baeverhead			5													
Big Horn			10		1		1	1								
Blaine			4													
Broadwater																
Carbon			1													
Carter																
Cascade		2	21	5	3				1					4		
Chouteau														1		
Custer			4													
Daniels																
Dawson			2													
Deer Lodge			2					1								
Fallon																
Fergus			1					1								
Flathead		4	3	8								1				
Gallatin			17	2												
Gerrard																
Glacier			11	1			2									
Golden Valley																
Granite																
Hill			11	2	1										32	
Jefferson																
Judith Basin																
Lake			2		2											
Lewis & Clark			8	2	1					1				1		
Liberty																
Lincoln																
McCone																
Madison																
Maagher			1													
Mineral			1													
Missoula		1	19	3										1	1	
Musselshell																
Park			3	2												
Petroleum																
Phillips																
Pondera												1				
Powder River																
Powell		1	1													
Prairie																
Revelle			2													
Richland			1													
Roosevelt			5												2	
Rosabud			4													
Sanders																
Sheridan																
Silver Bow			8		1											
Stillwater																
Sweet Grass							1									
Teton			1													
Toole																
Treasure															1	
Valley												1				
Wheatland																
Wibaux																
Yellowstone		1	45		2			2	1					1	2	
MONTHLY TOTAL	1991	9	193	25	11	0	4	5	2	1	0	2	1	8	38	0
	1990	5	121	11	16	2	4	3	0	0	0	6	2	5	2	0
	1989	1	111	17	32	0	6	3	1	0	0	2	1	9	5	0
TOTAL TO DATE	1991	85	1624	149	97	8	78	62	23	7	9	65	38	126	116	9
	1990	80	1443	157	208	12	152	64	7	4	10	81	46	108	40	18
	1989	46	1284	71	120	5	31	33	3	2	1	50	55	36	89	12
OTHER DISEASES:																
RUBELLA: Gallatin - 11																
E. COLI 0157: Lewis & Clark - 1																

MONTANA
RESIDENT AND NON-RESIDENT AIDS CASES¹
Acquired Immunodeficiency Syndrome (AIDS)
Definitive and Presumptive AIDS Cases
Surveillance Report - As of November 30, 1991

1. Disease Category	Adult/Adolescent		Pediatric		Total	
	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)	Cases (%)	Deaths (%)
PCP	46 (41)	34 (74)	1 (50)	1 (100)	47 (41)	35 (74)
Other Disease w/o PCP	64 (57)	41 (64)	1 (50)	0 (0)	65 (57)	41 (63)
KS Alone	2 (2)	0 (0)	0 (0)	0 (.)	2 (2)	0 (0)
<u>No Diseases Listed</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>	<u>0 (0)</u>	<u>0 (.)</u>
Total	112 (100)	75 (67)	2 (100)	1 (50)	114 (100)	76 (67)

2. Age	Cases (%)	3. Race/Ethnicity	Adult/Adolescent Cases (%)	Pediatric Cases (%)	Total Cases (%)
Under 13	2 (2)	White, Not Hispanic	98 (88)	0 (0)	98 (86)
13-19	2 (2)	Black, Not Hispanic	2 (2)	0 (0)	2 (2)
20-29	31 (27)	Hispanic	4 (4)	0 (0)	4 (4)
30-39	47 (41)	Native American	7 (6)	2 (100)	9 (8)
40-49	23 (20)	<u>Unknown</u>	<u>1 (1)</u>	<u>0 (0)</u>	<u>1 (1)</u>
Over 49	9 (8)	Total	112 (100)	2 (100)	114 (100)
<u>Unknown</u>	<u>0 (0)</u>				
Total	114 (100)				

4. Exposure Category	Adult/Adolescent		Total (%)
	Males (%)	Females (%)	
Homosexual or Bisexual Men	70 (69)	0 (0)	70 (63)
Intravenous (IV) Drug User	11 (11)	1 (9)	12 (11)
Homo/Bi IV Drug User	10 (10)	0 (0)	10 (9)
Hemophiliac	5 (5)	0 (0)	5 (4)
Heterosexual Contact	0 (0)	7 (64)	7 (6)
Transfusion With Blood/Products	0 (0)	2 (18)	2 (2)
<u>None of the Above/Other</u>	<u>5 (5)</u>	<u>1 (9)</u>	<u>6 (5)</u>
Total	101 (100)	11 (100)	112 (100)

	Pediatric		Total (%)
	Males (%)	Females (%)	
Hemophiliac	0 (0)	0 (0)	0 (0)
Parent at risk/has AIDS/HIV	1 (100)	1 (100)	2 (100)
Transfusion with blood/products	0 (0)	0 (0)	0 (0)
<u>None of the above/Other</u>	<u>0 (0)</u>	<u>0 (0)</u>	<u>0 (0)</u>
Total	1 (100)	1 (100)	2 (100)

Source: Montana AIDS/STD Program, MDHES, through November 30, 1991. Please contact Jim Murphy at 444-4744 if you have questions or comments.

As of November 30, 1991 there have been 321 cumulative positive HIV tests from 30, 686 tests conducted through the MDHES Public Health Laboratory since 1985.

Nationally, as of October 31, 1991, 199,406 cases of AIDS and 128,289 deaths have been reported to the Centers for Disease Control.

Nov-1991

¹Includes 85 Montana AIDS cases and 29 cases reported to Centers for Disease Control from other states who moved to Montana.



SYMPTOMS	COLD	FLU
Fever	Rare	Characteristic, high (102-104°F); lasts 3-4 days
Headache	Rare	Prominent
General Aches, Pains	Slight	Usual; often severe
Fatigue, Weakness	Quite mild	Can last up to 2-3 weeks
Prostration (Extreme Exhaustion)	Never	Early and prominent
Stuffy Nose	Common	Sometimes
Sneezing	Usual	Sometimes
Sore Throat	Common	Sometimes
Chest Discomfort, Cough	Mild to moderate; hacking cough	Common; can become severe
COMPLICATIONS	Sinus congestion or earache	Bronchitis, pneumonia; can be life-threatening
PREVENTION	None	Annual vaccination; amantadine (an anti-viral drug)
TREATMENT	Only temporary relief of symptoms	Amantadine within 24-48 hours after onset of symptoms

From the National Institutes of Health

NEW DRUGS ADDED TO AIDS
DRUG REIMBURSEMENT PROGRAM

Aerosolized Pentamidine (AP) and didanosine (ddI) have been added to the AIDS Drug Reimbursement Program. These drugs represent the first expansion of the ADRP which is in its fourth year of operation. In the past, only AZT has been available through the program which pays. The ADRP will provide treatments for individuals who are unable to afford the costs and are ineligible for other forms of public assistance.

The program will cover the cost of AP when used for prophylaxis for Pneumocystis

carinii pneumonia, a leading infection of individuals with HIV. AP is most effective for individuals who are not able to benefit from conventional treatments and have a CD4 count of less than 200/mm³.

Didanosine (ddI) has recently been approved by the Food and Drug Administration for treatment of HIV infection. It is the second such treatment to be approved for battling HIV itself, rather than opportunistic infections. Currently, individuals who are intolerant or no longer responding to AZT are candidates for ddI.

For more information on ADRP, call Jim Murphy at 406-444-4744.

Volume: 15: No. 11

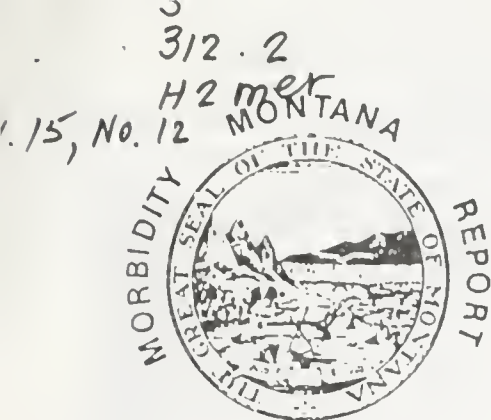
Month of: November, 1991

MONTANA MORBIDITY REPORT. ISSN #0745-5129 Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406)444-4740

POSTMASTER: Send address changes to Montana Morbidity Report, Cogswell Building, Helena, MT 59601

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Morbidity

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VOL. 15 NO. 12

December 1991

Montana State Department of Health and Environmental Sciences

LEISHMANIA AND THE BLOOD SUPPLY

Documents recently distributed by the Department of Defense, the Food and Drug Administration, and the American Association of Blood Banks describe the occurrence of a parasitic disease, leishmaniasis, in service members returning from the Persian Gulf area. In the DoD and AABB documents, advisories are issued recommending that all individuals who have traveled to specified areas of the Middle East since August 1, 1990, be deferred as donors of transfusable blood products.

Military physicians and researchers have discovered limited cases of the infection upon follow-up of service members returning from the Persian Gulf. These cases involve infection with the parasite Leishmania tropica, transmitted by the bites of sand-lies. Only twenty-two service members out of a half million have been found to have the leishmania parasite. Physicians at Walter Reed Army Medical Center and Research Institute identified the infection via a bone marrow culture of several patients. No cases involve life-threatening illness.

Military medical personnel are now trying to determine the prevalence of the disease among returning service members. Although the number of cases is believed to be small, efforts are being made to ensure that all cases are quickly detected and treated. This form of leishmaniasis is not contagious in person-to-person contact.

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MANAGING DIARRHEA	3
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Although there are no cases of this specific form being transmitted through blood transfusions, five cases of a related strain are reported in the medical literature to have been transmitted by transfusion of contaminated blood.

Although the risk of contamination is very low, the DoD and AABB, in the interest of safety, are recommending that all people who have travelled to the Gulf area (including Saudi Arabia, Kuwait, Iraq, Bahrain, Qatar, the United Arab Emirates, Oman and Yemen), since August 1, 1990, refrain from donating blood until after January 1, 1993.

The Centers for Disease Control are not currently recommending routine serologic screening for leishmaniasis in any asymptomatic person, regardless of their travel history.

Continued on Page 2

Questions from physicians and other health care professionals regarding clinical diagnosis and management of suspected cases should be directed to the CDC, National Center for Infectious Diseases, Parasitic Diseases Branch, in Atlanta (404) 488-4050.

HIV LABORATORY SLIP DEVELOPED

The Montana Department of Health and Environmental Sciences AIDS/STD Program and the Montana Public Health Laboratory have developed a laboratory request form specifically for HIV antibody testing. The test form allows non-identifying demographic information to be collected by the AIDS Program for analysis.

The test form, developed to collect information requested by the Centers for Disease Control, will be used for HIV tests after January 1, 1992. The form seeks information on the age of the subject, the subject's sex, the risk behavior reported by the subject and his or her reason for seeking testing. Although completion of the form is not mandatory, the information sought will provide valuable information and completion is strongly encouraged.

Prior to the development of the form such information was collected primarily through tests performed at state funded Counseling/Testing/Referral and Partner Notification sites. The eleven anonymous sites account for about one-half of all tests performed by the Public Health Laboratory. The information requested is routinely collected during mandatory pre-test counseling provided to the test subject. As a result, only limited information on details such as the age and reason for testing have been available.

As more complete information is collected, the ability of local and state health officials to tailor prevention efforts to the individuals at the greatest risk will be enhanced. In addition, more accurate information will assist agencies and organizations in planning for the delivery of services to those who test HIV positive.

For more information on the new laboratory slip please call the Montana AIDS Program at 444-3565 or the Montana Public Health Laboratory at 444-3444.

FALSE POSITIVE HIV TESTS REPORTED

Blood establishments have reported to the Food and Drug Administration and to the Centers for Disease Control that some prospective donors who recently received influenza vaccine have tested falsely positive on three commonly used screening tests -- those for detecting antibodies to Human Immunodeficiency Virus type-1, Hepatitis C, and Human-T-Lymphotropic Virus-type-1. Additional testing showed the false reactions were not related to infection with any of these viruses.

While these false positive reactions pose an inconvenience to blood donors and blood establishments, they do not represent a risk to the safety of the blood supply. The public should be assured that the current flu vaccine is safe. Flu vaccination does not carry risk of these diseases. It is important that people for whom flu vaccine is recommended continue to receive it. For more information, contact the Montana AIDS/STD Program, 444-3565, or the National AIDS Hotline, 1-800 342-2437.

ORDERING VACCINE FROM STATE AND FEDERAL PURCHASING CONTRACTS

The Immunization Program has recently received a number of inquiries regarding the use of federal contracts to order vaccine at reduced cost. In response, the program has developed a Federal and State Vaccine Contract Information Summary that may be useful if your agency is considering purchasing vaccine.

These contracts allow the ordering of childhood vaccines such as MMR and DTP as well as vaccines that are not a part of the childhood vaccination schedule, such as Hepatitis B and rabies vaccine.

If you would like a copy of this summary call the Montana Immunization Program at 444-5580.

HIV COUNSELING TECHNIQUES COURSE
1991 SCHEDULE

The Department of Health and Environmental Sciences AIDS Program, will be offering an HIV Counseling Techniques Course four times during 1992. This two day training session prepares individuals for providing HIV Counseling and Testing according to CDC protocols. It is also a useful update for health educators who do preventive education in the area of HIV/AIDS. There is no charge for the course. The following topics are covered: AIDS 101 Update, the HIV Antibody Test, Client Risk Assessment, Risk Reduction Education, pre- and post-HIV Test Counseling, Partner Notification and Safe Sex Education.

Dates and Locations:

February 18 & 19	Missoula
February 25 & 26	Northeastern Montana
April 21 & 22	Bozeman
September 22 & 23	Kalispell

Depending upon the demand, locations may change and/or another course could be added. If you are interested in this course, please call Amy Harris or Claudia Montagne as soon as possible to pre-register. The number at the Montana AIDS/STD Program is (406) 444-3565.

Care About
Clean Air...

...because when you can't
breathe, nothing else
matters.

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NOTICE
RECALL OF SPORICIDIN
COLD STERILIZING SOLUTION

On December 13, 1991, the U.S. Environmental Protection Agency (EPA) announced that Sporicidin Cold Sterilizing Solution (SCSS) failed tests to demonstrate spore-killing capability and that regulatory actions were being initiated to lead to its recall. Healthcare workers should stop using SCSS as a high-level disinfectant/sterilizer and choose another method to achieve high-level disinfection/sterilization. Other EPA-registered glutaraldehyde products remain approved for use as labeled. Physicians wanting more information may call the EPA at 1-800-858-7377.

NEW EMPLOYEE

DHES is pleased to welcome a new employee to the AIDS program. Kim Hauge has taken Jeannie Thrush's position as Administrative Aide. Kim comes to us from the Department of Commerce, where she worked for six years. She is originally from Sacramento, but has been living in Montana for the past 11 years. She has a 13 year old boy, an 11 year old girl, and four BIG dogs. She loves to water ski and run. Welcome to the Department, Kim.

MANAGING DIARRHEA

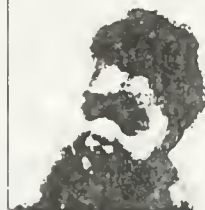
Diarrhea is a serious problem, and of concern to many of us in the health professions. It should also be of concern to parents, as it can result in dehydration and often requires hospitalization and IV therapy.

The National Oral Rehydration Therapy Project is a united effort by health and medical professionals to promote a uniform, safe, and cost-effective approach to the management of diarrhea in the U.S.

The following informational sheet is one of the materials developed by the Project to help you educate parents and others about managing diarrhea. This material has been sent statewide to 65 WIC clinics in Montana. Please make the information available to your constituents.



Diarrhea can be dangerous. It drains water and salts from your child. If these are not put back quickly, your child can get dehydrated and may need to be hospitalized. To protect your child follow these steps:



MANAGING DIARRHEA

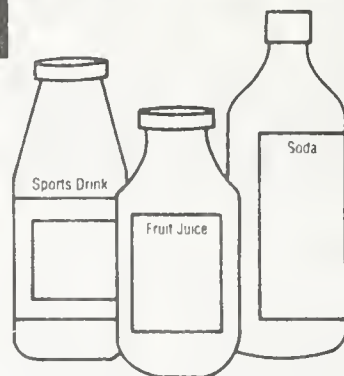
AS SOON AS diarrhea starts, give your child fluids right away. An oral electrolyte solution is the best fluid to give. This will put the water and salts back into your child's body that are lost with diarrhea.

- You can get these solutions at grocery and drug stores.
- If under 2 years old give 1/2 cup every hour using a small spoon. Call your doctor or public health clinic.
- If over 2 years old give 1/2 to 1 cup every hour.
- Keep giving the oral electrolyte solution until the diarrhea stops.
- If your child vomits, continue to give the oral electrolyte solution, using a teaspoon. Give one teaspoon every 2-3 minutes until vomiting stops. Then give regular amount according to age.
- Do not give sugary drinks such as Gatorade, cola drinks or fruit juice. They can make your child's diarrhea worse.

CONTINUE TO FEED your child as recommended by your doctor or public health clinic. Food will help your child stay healthy.

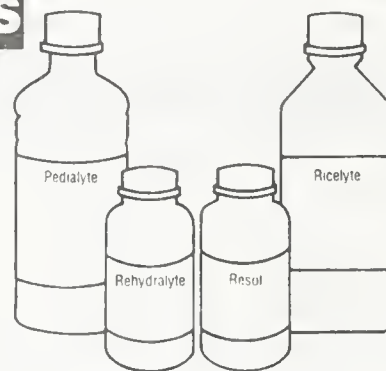
- Continue breast feeding.
- If on formula continue to give formula.
- If on solid foods continue to give regular diet. Good foods to give include cooked meat, cooked cereal, noodles or bananas.

NO



These have the **WRONG** amounts of salts and sugar.

YES



Oral electrolyte solutions have the **RIGHT** amounts of salts and sugar.

DANGER SIGNS OF DIARRHEA

Your child may need medical help if the diarrhea is more serious than usual. You should call your doctor or public health clinic immediately if:

- the diarrhea lasts more than 24 hours,
- the diarrhea gets worse,
- there are any signs of dehydration:

decreased urination

sunken eyes

no tears when child cries

extreme thirst

unusual drowsiness or fussiness



(202)625-2570

December 1991		Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
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Golden Valley																
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Hill			6		1									2	30	
Jefferson			2													
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Musselshell																
Park			3	1												
Petroleum																
Phillips			1													
Pondera							1									
Powder River																
Powell			1													
Prairie																
Ravalli			1	1												
Richland			2													
Roosevelt			4													
Rosebud			3													1
Sanders			1													
Sheridan													1			
Silver Bow		1	11	2				1								
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Teton																
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Treasure			1													
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Wheatland			1													
Wibaux																
Yellowstone			59	4	1		1		1					2	2	
TOTAL MONTHLY TO DATE	1991	6	216	34	10	0	3	8	1	0	0	1	2	6	33	4
	1990	6	121	9	16	2	6	9	0	0	0	1	0	6	1	0
	1989	3	116	10	32	1	1	6	0	0	0	0	3	6	5	15
	1991	91	1840	183	107	8	81	70	24	7	9	66	40	132	149	13
TOTAL TO DATE	1990	86	1592	166	208	14	158	73	7	4	10	82	46	14	41	18
	1989	46	1391	71	120	5	31	33	3	2	1	50	55	36	89	12
	OTHER DISEASES: Pertussis: Gallatin - 1 Legionella: Yellowstone - 2															



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ABOUT RADON CAN
HURT YOU.**

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local American
Lung
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Volume: 15 No. 12

Month of: December, 1991

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